Maternal and Child Health Services Title V Block Grant

State Narrative for Hawaii

Application for 2011
Annual Report for 2009

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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section.

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

Copies of the Title V Assurances and Certifications are available by contacting:

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D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published March 2009; expires March 31, 2012.

E. Public Input

Public input was obtained throughout the past year as part of routine staff presentations and participation in coalitions, advisory boards, conferences, professional and community meetings. Performance measure narratives were developed with input from collaborating agencies, community advocates, and families.

For a listing of the types of agencies and organizations that provide input into the Title V report see the Section III.E. on State Agency Coordination.

Copies of the Title V Block Grant Report and Application are routinely mailed to 25 agency partners, community representatives, and concerned individuals. Many of these stakeholders are also invited to join the Title V grant review. Copies of the report are also available directly from FHSD upon request by the public. Information on the Title V report and a link to Title V information system is also on the Department of Health (DOH) website.

To garner interest and input for the annual Title V grant report, the Title V agency has focused on analyzing and publishing Title V/MCH data in user friendly formats (fact sheets and short databooks) to raise awareness about health issues important to the MCH population. The publications have been an effective method to initiate discussion and solicit information/input for the annual Title V report and 2010 needs assessment. Dr. Don Hayes, the Title V agency's Centers for Disease Control-assigned epidemiologist, provided crucial guidance for the development of these projects. Title V funds are used to pay for Dr. Hayes' salary. The federal

State Systems Development Initiative (SSDI grant) has also been utilized to help develop greater epidemiology capacity and resources for this effort.

In 2008 FHSD completed a compendium of perinatal health fact sheets utilizing data from several Title V measures and indicators. Over 175 copies were distributed at a State Perinatal Summit held in October 2008 where stakeholders were asked for their input to identify state perinatal health priorities for the 2010 Title V needs assessment. An additional 500 copies were printed and were distributed to partner agencies and programs. Based on the feedback from stakeholders, more fact sheets have been developed on additional health topics including intimate partner violence, diabetes during pregnancy and characteristics of women with preconception obesity and its impact on birth outcomes. In July 2010 FHSD will publish an eight-year PRAMS Trend data report.

In August 2008, the Title V agency published a FHSD Profiles Databook to highlight the state Title V priority health issues and performance measures. Data from the key MCH datasets identified in Health Systems Capacity Indicator 9 in this report were used in the publication. The document also includes descriptive data on the MCH population, including some of the Title V Health Status Indicator data. The databook provides a description of programs and activities within the Title V agency that help improve the health outcomes tracked by Title V. Three hundred copies of the report were distributed and the publication is on the DOH website. The report was used to engage stakeholders to provide input to the Title V annual report and needs assessment.

In January 2010 the Title V agency published its 2009 State of Hawai`i Primary Care Needs Assessment Data Book. The Data Book serves as a source of comparative health statistics on 28 primary care service areas in the State of Hawai`i. The book demonstrates significant differences in risks related to geography, race-ethnicity, gender, age, education, poverty and other factors that may explain observed disparities. In consultation with community health providers, this edition broadened its perspective beyond maternal and infant health and socio-economic risks to include mortality and morbidity chronic disease measures. More than 500 copies have been distributed statewide and has served as foundation for many community grant applications.

A series of fact sheets are being finalized for each of the state priority health issues identified through the 2010 Title V needs assessment to educate and mobilize stakeholders to participate in the development of action plans and to support implementation. Drafts of the fact sheets have been circulated among key stakeholders for input and have generated thoughtful discussions about data, current resources, and collaborative strategies. All fact sheets will be placed on the DOH website when finalized.

II. Needs Assessment

In application year 2011, the 2010 Needs Assessment will be attached to this Section II.

An attachment is included in this section.

C. Needs Assessment Summary

Hawai'i Maternal Child Health Priorities

Seven priority issues were identified through the Title V Maternal and Child Health (MCH) needs assessment (NA) process. These priorities are expected to be the programmatic focus for the Family Health Services Division (FHSD), the state Title V MCH agency, in conjunction with many of our partnering organizations during the next five years (2010-2015). The 7 priorities for the state MCH population are:

1. Reduce the rate of unintended pregnancy
2. Reduce the rate of alcohol use during pregnancy
3. Improve the percentage of children screened early and continuously age 0-5 for developmental delay
4. Improve the percentage of youth with special health care needs age 14-21 years who receive services necessary to make transitions to adult health care
5. Reduce the rate of child abuse and neglect with special attention on ages 0-5 years
6. Reduce the rate of overweight and obesity in young children ages 0-5
7. Prevent bullying behavior among children with special attention on adolescents age 11-18 years

Changes in Priorities Since the Last Needs Assessment

Five priority needs were dropped from the list of nine:

1. Ensure that all infants and children receive appropriate and timely hearing evaluation and early intervention services;
2. Improve the oral health of children
3. Prevent underage drinking among adolescents
4. Reduce the rate of adolescent Chlamydia
5. Increase abstinence from smoking during pregnancy

Summary of Needs Assessment Process

The primary goal of the NA was to build FHSD public health capacity and develop staff leadership capability. To achieve this, nearly all the work for the NA was conducted using FHSD staff. The focus is on identifying state priorities and building partnerships to improve the health of the MCH population.

The NA process was managed by a Steering Committee comprised of FHSD senior management to provide guidance, assure progress, and coordinate efforts between work groups. A work group was established for each of the three target populations: 1) Women and Infants, 2) Child and Adolescent, and 3) Children with Special Health Care Needs.

The NA process involved several steps:

- Evaluation of previous needs assessment process and priorities
- Problem definition: identify preliminary list of health issues
- Prioritization: identify final list of state priority health issues utilizing specific criteria
- Problem Analysis: identify key goals, targeted behaviors, determinants/influencing factors, existing services & interventions
- Strategy Design: identify 1-3 strategies and develop a logic model for each strategy

Issue Identification began in earnest at a November 2008 Division meeting with an evaluation of existing priorities and identification of new issues. NA training was conducted in January 2009 and the FHSD NA process reviewed. The 3 population workgroups (CSHN, Women/Infants, Children/Youth) compiled/reviewed stakeholder input (through extensive stakeholder surveys), reviewed data, and assessed internal and external capacity to develop a short-list of issues for consideration by the NA Steering Committee.

Priority-Setting was conducted in June 2009 by the NA Steering Committee. Eight issues were identified; however, one was later deleted.

Issue workgroups were formed for each priority. Problem Analysis began with a training conducted following priority setting and problem maps were completed for each of the issues based on literature reviews, data, and other expert consultation. Performance measures were identified for the Title V annual report.

To complete Strategy Design the Issue groups continue to conduct resource assessments and network with stakeholders to identify feasible strategies given the challenging economic climate. Logic models will be developed for strategies once finalized.

Data Publications
To assist needs assessment work several data publications were developed. The reports also serve as routine surveillance documents to monitor the health for the MCH population. The leadership and efforts of the CDC-assigned MCH Epidemiologist and resources from the State Systems Development Initiative grant have been essential to support the achievements in this area. The publications include: A 2008 Compendium of Perinatal Fact Sheets, Family Health Services Division Profiles, Primary Care Needs Assessment Databook, PRAMS Eight Year Trends Report, Hawaii Children's Health Disparities report and Fact Sheets for the 7 state priority issues.

The fact sheets have been instrumental with engaging stakeholders and initiating discussion around strategies. Future publications include a summary of the National Survey of CSHCN data and a short brochure on the Early Childhood data from the National Survey of Children's Health as requested by stakeholders.

Stakeholders
Input from stakeholders was collected for all steps in all phases of the NA including planning of the process. Various methods were used to assure ongoing input and participation including videoconferencing, telephone conference calls, community meetings, focus groups, coalition meetings, email, surveys and interviews. Stakeholders were used strategically to take advantage of their specific expertise and interest in the NA process. The process has helped to identify new stakeholders and improve working relationships with existing agency partners.

Next Steps in Needs Assessment Process
Evaluation comments from the NA Issue groups will be reviewed carefully by the NA Steering Committee to help improve further NA work and build staff capacity. Particular attention will be placed on targeted trainings requested by staff and stakeholders. FHSD will build on the lessons learned, continue ongoing evaluation with all NA participants to strengthen the process. Issue workgroups will continue to network with stakeholders to identify collaborative strategies and focus on implementation.

An attachment is included in this section.

III. State Overview

A. Overview

GEOGRAPHY

Hawaii is situated almost in the center of the Pacific Ocean and is one of the most isolated yet populous places on Earth. The west coast of North America is 2,400 miles from Honolulu, roughly a 5 hour flight by air. Six time zones separate Hawaii from the eastern U.S. This means 9 am (eastern standard time) in Washington, D.C. is 6 am in Los Angeles and 4 am in Hawaii.

The State is composed of 7 populated islands located in 4 major counties: Hawaii, Maui, O‘ahu, and Kaua‘i (see attached Figure 1). The county is the lowest civil subdivision in the state. As a result, counties in Hawaii provide some services, such as fire and police protection, that in other states are performed by cities or towns. Counties also elect a mayor and council. Likewise, the state government is responsible for functions usually performed by counties or cities in other states. Hawaii is the only state, for example, with a single unified public school system.

Approximately 71% of the state population resides in the City and County of Honolulu on the island of O‘ahu, concentrated in the Honolulu metropolitan area. The neighbor island counties are Hawaii, Kaua‘i (includes Ni‘ihau) and Maui (includes Moloka‘i, Lana‘i, and Kaho‘olawe, the latter is unpopulated).

Only 10% of the state's total land area is classified as urban. The City and County of Honolulu is the most urbanized with a third of its land area and 96% of its population in urban communities. The majority of tertiary health care facilities, specialty and subspecialty services are located on O‘ahu. Consequently, neighbor island and rural O‘ahu residents often must travel to Honolulu for these services. Interisland passenger travel is entirely by air. Air flights are frequent, but comparatively expensive. Airfare costs can be quite volatile based on varying fuel costs. This creates a financial barrier for neighbor island residents since round-trip airfare costs range from $130 to over $200.

Geographic access is further limited because public transportation is inadequate in all areas of the state except for the city of Honolulu. Residents in rural communities, especially on the neighbor islands, need an automobile in order to travel to major population centers where hospital, specialty, and subspecialty services are available. Because of the mountainous nature of the islands, road networks have been sparse and, in some places, limited to a single highway near the coast. Access to emergency care on neighbor islands often requires the use of helicopters or fixed-wing aircraft.

DEMOGRAPHICS

According the 2008 Census estimates, 1.3 million residents live in Hawaii. The state's population continues to slowly shift away from urban Honolulu. O‘ahu is still where nearly three-fourths of the state's population lives (905,034 residents), but its share of residents is slowly declining: from 72.3% in 2000 to 70.3% in 2008. Population growth is largely occurring on the neighbor islands. Over 13% of Hawaii's people were estimated to be living on the Big Island (175,784 residents) in 2008, 11.2% (143,691 residents) in Maui County, and almost 4.9% (63,689) on Kaua'i.

Hawaii's population, like the U.S. as a whole is aging. The median age of Hawaii residents increased from 36.2 to 38.0 over the last decade, higher than the national average of 36.7. Between 2000 and 2008 there were increases in the proportion in those 20-34, 55-74, and 75 years and older, while the proportion of children and youth age 0-19 years and younger adults 35-54 years decreased. The largest increase was among the elderly, those 75 years and older, representing a 33% increase since 2000, followed by a 26% increase among those 55-74 years of age.

ETHNIC DIVERSITY

Unlike most of the United States, the ethnic composition of the state's population is very heterogeneous and no single ethnic majority emerges. Caucasian, Japanese, Filipino, and Part-Hawaiian are the largest ethnic groups and their proportions differ by county. These four ethnic groups combined represent about 74% of the state's population according to the 2008 Census estimates. Some 18.6% of the people in Hawaii indicate they are of two or more races.

Hawaii is considered a gateway to the U.S. for immigrants from Asia and the Pacific. According to U.S. Census and the Immigration and Naturalization Service, 17.8% of Hawaii's population is foreign-born, the 6th highest percentage according to the 2008 Census. Nearly 35,000 immigrants were legally admitted to the state between 2005 and 2009 mainly from the Philippines, Japan, Korea and Vietnam. Smaller groups of Hispanic immigrants have settled in parts of Maui and Hawaii island, attracted by jobs in tourism and agriculture. Estimates of illegal immigrant in Hawaii range from six to nine thousand.

Because of this ethnic diversity, there are a number of people who speak English as a second language. In 2008, approximately 7.8% (13,791) of the state's public elementary school children were enrolled in the Students with Limited English Proficiency Program. According to the Governor's Council on Literacy, over 155,000 adults or an estimated 16% of Hawaii's adults are functionally illiterate. The 2008 Census reports that 254,172 people in Hawaii speak a language in the home other than English.

Other sub-populations within the state include U.S. Armed Forces personnel and their dependents which comprise an estimated 6.8% of the state population (110,713 people).

ECONOMY

Unemployment and the recession is the primary concern for Hawaii. In 2007 Hawaii had one of the lowest unemployment rates (2.3%) in the nation; by 2009 Hawaii's unemployment rates increased to 7.4% with a record 47,000 individuals unemployed. Hawaii is still reporting one of the lowest unemployment rates in the nation. Hawaii with a current unemployment rate of 6.7% compares favorably to the seasonally adjusted national unemployment rate of 9.9%.

The lowering of the unemployment rate in several years is encouraging. However, the unemployment rates across the islands are quite variable: Oahu 5.2%, Lanai 6%, Maui, 8.3%; Kauai 8.9%, Hawaii 9.5% and Molokai 11.8%. Another encouraging sign was attendance at a recent job fair of 5,000 people, somewhat lower than the 6,500 that attended last year's fair. The job market was influenced by the addition of 1,600 jobs as a result of federal stimulus funds. Regardless, there are still 42,569 individuals reported as unemployed; and 8% of Hawaii workers report they work multiple jobs to make ends meet.

Given recent performance, the Hawaii economy is projected to show a 1.1% growth in 2010; and expected to increase modestly to 1.4% in 2011.

Hawaii's poverty rate in 2008 was 9.1% compared to 8% in 2007. More than 115,000 residents live in poverty. Hawaii's homeless rate rose from 10-15%: 3,350 were in shelters and 2,600 were unsheltered. Over 37,000 or 11.6% of children in Hawaii live in households below the federal poverty level. In 2007, 36.2% were living in households at 200-399% FPL.

Bankruptcy filing in April 2010 were up 56% from 2009 (391), this is the highest level in four and half years. Bankruptcies have risen for three consecutive months as people continue to experience economic problems due to unemployment or fewer hours worked.

GOVERNMENT

Faced with a $1.2B deficient for the biennium (out of a $10B budget) the Governor's response was to cut services to the public by restricting government contracts for health and human services by 14%; instituting 2 day a month mandated furloughs, and to cut more than 800 state funded government positions equating to a 1% reduction in government workforce. Some

government agencies were more greatly affected than others; however the overall net effect was less service provision for the general public and vulnerable populations.

The May 2010 State Council on Revenues reported some indication of the economy slowly rebounding with a prediction that FY 2010 will end with a 0.5% increase in tax revenues; in March the Council predicted a 2.5% decline in revenues. The Council now projects a 6% increase in revenues for FY 2011.

TOURISM

Hawaii's economy is largely driven by the tourism, real estate and construction sectors. The current national recession has severely impacted Hawaii's primary economic driver, tourism; although the State is beginning to witness some encouraging signs of recovery. According to the Department of Business, Economic Development and Tourism, visitor arrivals are expected to increase 2.6% in 2010 and 4.1% in 2011. This modest increase is welcomed after experiencing a 10.6% reduction in 2008 and an additional 4.5% in 2009 in visitor arrivals. Hotel occupancy rates are beginning to see a modest increase due to marketing reduced hotel rates to encourage visitors. Hawaii is expected to see 6.7M visitor arrivals for 2010.

Hotel occupancy rate for February 2010 was 73.5% full as compared to 72.5% in 2009. The improvement in hotel occupancy comes at a price for hotel owners who have slashed room rates over the past several years to attract guests. The average daily room rate fell to $175 compared to $188 in 2009. Again the hotel occupancy rates varied by county: Oahu 80.5%, Maui 77.9%, Kauai 62.8%, Hawaii 62.4%.

CONSTRUCTION

In September 2009, residential building permits were projected to fall 44% and it has pushed back by a year its forecast for a surge in federal and state infrastructure spending. Year-to-date nonresidential construction permits, valued at $811 million, were 24% lower than the same time last year.

HIGH COST OF LIVING

While Hawaii has seen some reduction in the cost for single family homes and condominiums, housing costs are still substantially higher than the national average. The median housing cost is $563,000 for a single family dwelling and $388,000 for a condominium. In October 2009, RealtyTrac ranked Hawaii 17th among states for foreclosures. Foreclosures in Hawaii grew more than 134% from the prior year.

Hawaii was listed for the fifth straight year as having the least affordable rental units in the Nation. An estimated 44% of Hawaii residents rent; an average monthly rate for a two bedroom is about $500-$2,000 and $900-$1,000 for a studio. This often leads to more than one family living within the same dwelling.

While many in Hawaii have witnessed either a cut in salary or reduction in hours worked; other costs in the community continue to rise. Gasoline prices have risen to an average of $3.55 per gallon, with cost over $4 on the neighbor islands. Higher crude oil rates translate into increased cost not only for personal ground transportation, but rate increases for electricity and other consumables that must be imported to Hawaii. Service/User fees for county level services have also increased.

The Hawaii General Excise Tax is currently 4% statewide. Oahu has an additional 1/2% surcharge imposed to fund rail mass transit. All goods and services on Oahu, including the City and County of Honolulu are taxed at 4 1/2% of gross sales. This GET is assessed on the provider of the goods and services and in turn passes the cost on to the consumer at a rate of 4.712% on Oahu and approximately 4.2% on Neighbor Islands. During the past three decades, Hawaii has consistently had one of the nation's highest tax burdens. Estimated at 10.6% of income, compared to the national average of 9.7%, Hawaii ranked 5th highest for its state/local tax

burden.

Health Insurance premiums have risen on average 10% each year for the past three years. This has placed additional burdens on small business and government employees who were required to absorb all increases.

POLITICAL CONTEXT

Governor Lingle submitted her last Biennium Executive Budget to the Hawaii State Legislature. She will be completing her eighth year in office in December 2010. The 2010 legislative session was the most acrimonious in decades because of the severe budget shortfall and political differences over strategies to address the projected $1.2B deficit. The Governor's approach was conservative: cut government spending, services and staffing. Health and Human Services providers expressed concern that the budget was being balanced on the neediest, with cuts to benefits and services. Government employees and unions expressed concern that the budget was being balanced on the backs of staff with reduction in force, furloughs and pay cuts. Health and Human Services contractors were outraged to learn that the last quarter billings of fiscal year 2010 may not be paid until the first quarter of fiscal year 2011; effectively a three month delay in payment. A huge controversy arose over the furloughing of teachers twice a month, resulting in Hawaii having the lowest number of school days in the nation.

The Hawaii State Legislature chose to utilize the Hawaii Emergency and Relief Fund (Rainy Day set asides from a portion of the State's Master Settlement Tobacco Fund) and the Hurricane Relief Fund to reinstate teacher furlough days and funding for essential health and human services. This included funds for Healthy Start Home Visiting Program, Respite and Community Health Centers. However, the actual release and expenditure of these funds will depend upon the Governor's signage of the bills. At this point it is anticipated that the Governor will veto the budget proposed by the Legislature.

Balancing the State's budget and the restoration of services was the central issue occupying 90% of the legislative agenda. The most controversial issues were school furloughs, the Honolulu Rail Transit project and equal benefits for same sex partners.

The Legislature has set aside $67M of the Hurricane Relief Fund to restore 18 furlough days for the 2010-11 school year. Governor Lingle has offered $57 M to restore the majority of the furlough days for "essential" staff and suggested that the teachers voluntarily restore other days. The resolution of this issue has been negotiated between the Governor, the Board of Education, Department of Education and the Hawaii State Teachers Association. The agreement reached includes the restoration of 18 furlough days with the $57M form the Hurricane Fund, teachers agreeing to use 6 planning days as instructional days, and a zero percent credit line for $10M. The credit line cannot be used for salaries, only operating expenses. Governor Lingle has also advocated for the decentralization of Hawaii's singular school and one school board system, and has opposed having an elected school board. The Hawaii State Legislature passed legislation to place the question of school board selection on the election ballot this Fall.

The State Legislature considered the redirecting of the Honolulu Transit Tax to balance the state budget. While this did not occur, the Governor and Mayor have been at odds over the release of the Environmental Impact Statement, the feasibility and cost of the rail which will be the largest public works project in the history of the state; thus jeopardizing the timely release of federal funds.

Hawaii as many other states is entering the campaign season. The election will radically change the State's political landscape in 2011 with the election of a new Governor, Lt. Governor, Congressional Delegate (one of only four seats), and virtually a new legislative body as many current members have reached term limits. The election of a new Governor will bring the appointment of a new cabinet including a new Director of Health and Deputy Directors.

WELFARE REFORM

In Hawaii the Department of Human Services (DHS) administers the Temporary Assistance to Needy Families (TANF) program. The state responded to the 1996 federal Welfare Reform Initiative by creating a TANF waiver referred to as PONO (Pursuit of New Opportunities). The waiver expired and is currently operating under federal guidelines.

When the program was implemented in 1996, the welfare population was approximately 20,825 cases. The current population as of March 2010 is 7,356 cases. Of that number, approximately 5,060 clients are identified as eligible to work.

All "able-bodied" TANF recipients experienced a 20% reduction in their cash benefits in the first year of the PONO program. Those individuals who are currently employed while in the program (about 2,000 individuals) have been able to earn back this 20% reduction, as well as an additional amount of disregarded income for exiting the program and remain off further assistance.

An additional group of over 2,100 recipients are obtaining job experience with volunteer placements. Since July 2007 DHS increased the payment standard in response to the needs of these individuals and to account for the increase in the cost of living.

The First-to-Work (FTW) Program serving parents receiving TANF has been active and services approximately 5,077 cases per month and an unduplicated number of 9,051 per year.

HEALTH INSURANCE

Historically, Hawaii has had a large proportion of its population covered by some form of health insurance. In the 1980s, Hawaii's uninsured population was estimated at 5%, and the state was credited as having the lowest uninsured rate in the U.S. This is a legacy from traditional Hawaiian society; the subsequent plantation era where medical care was provided for workers, and the rise of strong labor unions.

Prepaid Health Care Act

The generally accepted principle of broad or universal access to health care is reflected in the passage of the Hawaii Prepaid Health Care Act of 1974. The Act requires employers to provide a group health plan for employees working at least 20 hours a week for at least four straight weeks and earn at least $542 a month. The law also mandates a minimum set of benefits that must be provided.

Hawaii is the only State with such a requirement and was successful in obtaining a waiver from the federal Employee Retirement Income and Security Act (ERISA), which prohibits state regulation of self-insured employers. The law does not require employers to cover dependents, so families may be omitted from coverage. Recent large increases in insurance premiums over the past few years have raised concerns about the Act and its impact on businesses in Hawaii.

Private and public health insurance covered an estimated 90 percent of Hawai'i residents in 2007. Private health insurance covered about 56 percent of residents. Of those people covered by private health plans in Hawai'i, 93 percent were covered through employment-based plans. The number of residents in public-sponsored insurance programs remained fairly stable between 1995 and 2007 at about 36 percent of the resident population.

From 1992 to 2007, the proportion of the population with overlapping coverage has increased by 80 percent. (Overlapping coverage refers to an individual's coverage by more than one insurance plan.) In 2007, nine percent of covered individuals, or 1 in 11 individuals, had overlapping coverage.

UNINSURED

Although the Hawai'i resident population is relatively well insured compared to populations in most other states, direct and indirect problems persist. Many low-income Hawai'i residents

remain uninsured and a significant number of full-time and part-time workers remain uninsured. Over 50 percent of the total number of uninsured in Hawai'i are working part-time or full-time.

The State uninsured rate was 7.8 % in 2008 compared to 15.4% nationally according to the Census Bureau 2009 Current Population Survey. Hawaii had the second lowest uninsured rate behind Massachusetts. However, this data reflects uninsured rates before the major effects of the state economic decline occurred in 2009.

A disproportionate number on uninsured reside on the islands of Hawaii, Kauai, and Maui rather than on Oahu, where the majority of the state's population lives.

INSURANCE MARKET
Information on Hawaii's health insurance market is from the Hawaii Health Information Corporation. As in the rest of the nation, the two dominant types of managed care organizations are health maintenance organizations and preferred provider organizations. Nearly 35% of Hawaii residents with insurance were enrolled in an HMO in 2007. Of these HMO enrollees, one out of three participated with one of the QUEST plans. Almost 40% of Hawai'i's residents were enrolled in a PPO in 2007.

Traditional fee-for-service coverage declined by 63% between 1992 and 2007, and makes up 11% of covered lives. In 2007, all of the fee-for-service covered lives were covered by public insurance (either Medicare or Medicaid). Both the federal and state governments are in the process of changing coverage for these populations to managed care options so this percentage is expected to change.

The financing of health care in Hawaii's private sector is dominated by two health plans: the Hawaii Medical Service Association (HMSA, the Blue Cross and Blue Shield plan) which was founded in 1935, and Kaiser which began operating in Hawaii in 1958. In 2007 HMSA insured 60% of the Hawaii market, while Kaiser covered 20%. The other major insurers in the state are Hawaii Management Alliance Association (HMAA) and University Health Alliance (UHA). All 4 insurers are non-profits and exempt from taxes. A new for-profit insurance plan, Summerlin Life & Health Insurance, began offering services in 2005.

Although there was a significant commercial insurance presence at one time, it has dwindled due to the State's isolation, limited consumer market and aggressive competition from the HMSA and Kaiser. To address Hawaii's shrinking health insurance market and rising health costs, legislation was passed in 2002 to regulate health insurance plans to assure insurance rate increases are not excessive, yet sufficient to keep insurance companies viable in the long term. Hawaii was one of the last states in the U.S. to pass such legislation.

Overall, the number of covered lives in government sponsored plans has increased 29% since 1995, while the percent of individuals covered by private plans increased 2%. In total, government programs represented 36% of the covered lives in 2007.

Medicare, the federal government's coverage for the elderly, accounted for 35% of the government program covered lives in 2007; QUEST and Medicaid, state and federally-funded programs, represented 29% and 8% of government funded health plans respectively. TRICARE, the federal government's coverage for military-dependent and military retiree health care, accounted for 28%.

MEDICAID
The Hawaii QUEST Expanded demonstration project is a Medicaid waiver project administered by the Department of Human Services Med-QUEST Division (MQD) that began in August 1994. QUEST is an acronym that stands for: Quality Care, ensuring Universal Access, encouraging Efficient Utilization, Stabilizing Costs, and Transforming the way health care is provided. QUEST has 2 basic objectives: to expand medical coverage to include populations previously ineligible for

Medicaid and to contain costs by shifting fee-for-service to a managed care delivery system. Savings realized from such a shift would be used to expand coverage.

In 1996, economic changes led to a tightening of QUEST eligibility. The income requirement was changed from 200 percent of the Federal Poverty Level (FPL) to 100 percent, and enrollment was capped at 125,000 members, down from the high of 160,000. Certain groups are not subject to the cap and can enroll at anytime: pregnant women, children under 19 years of age, foster children and children in subsidized adoptions under age 21, adults whose incomes do not exceed the TANF payment limit, and people who apply within 45 days of losing their employer sponsored coverage due to loss of employment.

The Medicaid population of clients 65 years or older and disabled of all ages (commonly called the aged, blind, and disabled (ABD) population) was covered under a separate fee-for-service program. Starting February 2009, the ABD population transitioned into a managed care system through the new QUEST Expanded Access (QExA) program. MQD designed the QExA program to provide service coordination, outreach, improved access, and enhanced quality healthcare services by health plans through a managed care delivery system to this Medicaid population. QExA health plans coordinate benefits across the continuum of care to include acute and primary care, behavioral health, and long-term care services. In 2008, DHS awarded the 3-year QExA contracts to two health plans: Evercare and ‘Ohana Health Plan.

As of January 2010 the QExA enrollment was 41,671; QUEST enrollment was 205,106 for a total Medicaid enrollment of 249, 875. Due to the state economic downturn, Medicaid programs observed an approximately 13% increase in recipients for two successive years. This unexpected growth of the program with federal restrictions under the American Recovery and Reinvestment Act that prevented states from decreasing eligibility resulted in a budget shortfall and the need to delay two months of health plan capitation payments (one month's for 6 weeks, and a second month's for 2 weeks). DHS earnestly awaits a six-month extension of the increased federal medical assistance percentage.

Hawaii implemented the State Children's Health Insurance Program (SCHIP) as an expansion of Medicaid and QUEST in 2000. As a result, children under 19 whose family incomes do not exceed 300% FPL are eligible under QUEST. This ensures that all children from families with incomes at or below 300% FPL have access to the full QUEST benefit package with no cost to families up to 250% FPL and with a reasonable premium for families with income from 251-300% FPL. Premiums for QUEST-Net will be reduced from $60 a month to $15-$30, depending on income. There is no assets test.

Children who are legal immigrants arriving after August 1996, refugees and those born in the Marshall Islands and Federated States of Micronesia and Palau were eligible under both SCHIP and QUEST effective July 1, 2000 under a state funded immigrant program.

In January 2008, the state started a pilot Keiki Care plan that provided free health insurance for children up to 300% FPL. The bill covered premium payments for children in Med-QUEST's programs whose household incomes are between 251-300% FPL. DHS decided to cancel the pilot later in the year due to poor performance.

QUEST allows participants to select medical plans from the three current participating providers: HMSA, Kaiser, and AlohaCare. The three QUEST health plans offer additional services for disease management and some plans will offer health promotion programs for enrollees. Med-QUEST also implemented a new quality assurance program. Plans receive financial incentives for meeting quality performance standards and are assessed penalties if they fail to meet baseline requirements. As of January 2010 HMSA covered 52.1 % of QUEST enrollees, Kaiser 11.8%, and AlohaCare 35.1%, (another 1.0% remain under QUEST FFS). Not all providers are available on each island.

Dental coverage is a comprehensive benefit for children but limited to emergency and palliative services for adults and was moved from managed care to fee-for-service in October 2001.

In December 2006, DHS reinstated adult dental benefits - including periodic exams and cleanings - to help up to 95,000 men and women eligible for Medicaid. The MQD ended this dental program on August 10, 2009. At this time, the State only pays for emergency dental services, such as tooth extractions for adults.

Through a Medicaid QUEST waiver in 2006 DHS also expanded services by covering more low-income adults. Through the new QUEST-ACE (Adult Coverage Expansion) launched by DHS in March 2007 benefits are provided for inpatient and outpatient care, emergency room visits, mental health services, diagnostic tests, immunizations, alcohol and substance abuse treatments, dental care and prescription drug coverage. Men and women over the age of 19 without dependent children are eligible whose annual earnings are at or below 200% of the FPL. The program is designed to help adults who could not previously qualify for QUEST due to the statewide enrollment cap imposed in 1996.

The waiver also allowed the state to continue to make direct payments to hospitals to offset the costs of caring for the uninsured.

DHS has plans to implement a new economic stimulus program that will increase health care coverage by providing a health insurance premium subsidy to employers who hire unemployed individuals.

STATE CHILD HEALTH INSURANCE PROGRAM

The State Children's Health Insurance Program (SCHIP), enacted in August, 1997, provided new incentives for states to extend public health insurance coverage to low-income uninsured children. The federal government offered states a higher federal match and greater flexibility to design their programs than they enjoyed under Medicaid. Hawaii uses Tobacco Settlement revenues to fund the State match for SCHIP.

The Department of Human Services (DHS) is the lead agency in Hawaii for the State Child Health Insurance Program (SCHIP). Hawaii's SCHIP program, a Medicaid expansion, began on July 1, 2000, and covers all children under 19 years of age with family incomes up to 300% of the Federal Poverty Level (FPL) for Hawaii. There is no waiting period for SCHIP eligibility. As of January 2010, 23,621 children were enrolled in SCHIP.

Effective July 1, 2000, legal immigrants, refugees, and those born in the Marshall Islands, Federated States of Micronesia and Palau were eligible for QUEST-like health coverage under a state-funded immigrant children's program which has the same eligibility requirements as QUEST.

In July 2009, MQD used the provisions of Section 214 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) to amend the Medicaid State Plan retroactive to April 1, 2009. Section 214 of CHIPRA extends federal medical assistance to alien children under nineteen years of age and alien pregnant women who are Legal Permanent Residents or citizens of a Compact of Free Association nation. Effective July 9, 2009, MQD began to convert the children and pregnant women covered in the State-funded programs to the appropriate Section 1115 QUEST Expanded programs. Therefore, as of January 2010, the immigrant child enrollment was 38 since the majority of children in this program (approximately 3,800) were converted to a Medicaid program that received Federal funds.

STATE DEPARTMENT OF HEALTH: CURRENT PRIORITIES & INITIATIVES

DOH Director Fukino identified the following priorities for the Department of Health in 2006:

- Assuring a viable and sustainable mental health system of care.
- Disaster readiness and response.

- Assuring access to quality health care, including the development of an EMS Trauma System Plan and the expansion of tele-health.
- Assuring a continuum of quality services for the care of seniors and disabled individuals.
- Improving departmental processes, reflective of current business standards.
- Primary Prevention: the promotion of good nutrition, exercise, and smoking cessation.

However, since FY 2009 the Department's budget has been reduced by 17% and has witnessed a 12% reduction in staffing. Therefore, Dr. Fukino has had to reprioritize programs to preserve its regulatory, statutorily mandated services and emergency response capacity. Eligibility criteria for many programs including family health services have been decreased to serve the neediest or more chronically ill.

An attachment is included in this section.

B. Agency Capacity

Public Health in Hawaii, including Title V, continues to focus on the core public health functions of assessment, policy development and assurance as outlined in the 1988 Institute of Medicine Report, The Future of Public Health. While there is still a broad emphasis on ensuring access to quality and affordable health care and the elimination of health disparities, we have seen a shift of resources to address global threats to public health. Greater emphasis has been placed on departmental readiness to address bioterrorism, global disease detection, the pandemic spread of disease and community wide immunization.

A clear example of this was Hawaii's response to the H1N1 pandemic which included state operated school immunization clinics, and coordination with all health care providers for the distribution of vaccines and the tracking of the spread of disease. Hawaii was ranked 8th best in the nation with 24% of its residents vaccinated between October 2009 and February 2010. Hawaii ranked 1st in the nation for regular flu immunization, with 55% of its residents vaccinated.

Also a continued emphasis for the Department of Health (DOH) is the reduction of the burden of chronic disease with a concerted effort to address the obesity epidemic.

Hawaii's Title V programs work to ensure statewide infrastructure building functions such as data collection, needs assessment, surveillance, planning and evaluation, systems and policy development, monitoring, provision of training, and technical assistance to assure quality of care.

The challenge for public health is to assure that the health of the community is improved and protected given that health status is influenced by a myriad of societal influences and the complex and ever changing nature of health care financing and delivery system.

In Hawaii the Title V agency is the Family Health Services Division (FHSD) in the State Department of Health. FHSD is organized into the 3 Branches: Children with Special Health Needs Branch (CSHNB), Maternal and Child Health Branch (MCHB), and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) Services Branch. The mission of FHSD is "to improve the health of women, infants, children and adolescents and other vulnerable populations and their families by increasing public awareness and professional education about the importance of a life course perspective; advocating for systemic changes that address health equity and the social determinants of health; and assuring a system of health care that is family/patient centered, community based, and prevention focused with early detection and treatment, habilitative and rehabilitative services for those with chronic conditions".

Our vision is to assure that systems are in place to address the full continuum of care throughout the life cycle from preconception to birth to adolescence to adulthood for Hawaii's population and address the health and safety needs of vulnerable individuals, children and youth, with particular attention to children with special health needs.

The Division goals are:

1. Pregnancy/conception shall occur by choice and under circumstances of lowest risk.

2. Every woman will utilize appropriate services and engage in healthy behaviors to optimize health outcomes.

3. All infants, children and adolescents, including those with special health care needs, will receive appropriate services to optimize health, growth and development.

4. All families will have a safe and nurturing environment, free of violence and will engage in behaviors to promote optimum health.

5. Access to quality health care shall be assured through the development of a comprehensive, coordinated community-based, patient/family-centered, culturally competent system of care.

6. FHSD shall have the necessary infrastructure to support the implementation of the core public health functions.

COLLABORATION & COORDINATION

The current administration has placed a priority on data and the tracking of health outcomes. Tobacco Settlement funds have been used to fund the Hawaii Outcomes Institute in conjunction with the School of Medicine to increase the research and epidemiological capacity of the state. Similarly, FHSD has strengthened its capacity to perform the ten essential public health functions by encouraging staff to participate in data analysis and management training sponsored by the Hawaii Outcomes Institute. FHSD has enhanced its data capacity through increased partnerships with the DOH Office of Health Status Monitoring; investing federal State Systems Development Initiative, Title V, and Primary Care office resources into the Hawaii Health Survey, the Pregnancy Risk Assessment Survey, and other health surveillance tools; and maximizing use of a Centers for Disease Control-assigned Title V funded MCH epidemiologist. WIC, PRAMS and Birth Defects Monitoring data are included in the DOH's Data Warehouse.

As funding for direct health care services shifts away from public health agencies to the medical community and other providers, the role of the Title V program changes. In the context of this changing health care system, the Hawaii Title V agency works to promote and develop an environment that supports the optimal health of all women of child bearing age, infants, children, adolescents and families. Collaboration and coordination is inherent in the work of the Title V agency; it would be impossible to meet the myriad of Title V objectives without intra and interagency efforts. A few examples of this include the coordination with the DOH's:

- Injury Prevention Program to assess and align our efforts to reduce child abuse, bullying, automobile injuries and sleep related deaths;
- Dental Health Division to address the issue of oral health promotion through WIC, school based and community health clinic activities;
- Healthy Hawaii Initiative to reduce obesity through the joint promotion and physical activity and breastfeeding promotion. Joint collaboration resulted in a two year federal grant for a Baby Friendly Hawaii project;
- Child and Adolescent Mental Health Division and the Mental Health Transformation Grant joint sponsorship of an annual summit to promote infant and child emotional wellness.

Example of inter-agency and community agency collaboration include:

- In conjunction with Kapiolani Medical Center for Women and Children (KMCWC), the joint creation of cranial-facial clinic;
- Women's Health Month and Children and Youth Month's calendar of events.
- Joint planning of the Hawaii Primary Care Association Annual Meeting;

• In collaboration with DHS and KMCWC, the assurance that all foster children will receive a full physical and emotional evaluation, including an assessment for potential fetal alcohol affects;
• Survey & report on C-section and early induction in collaboration with March of Dimes and Healthy Mothers Healthy Babies;
• Provider training for substance abuse screening and brief interventions in conjunction with Ira Chasnoff, MD, with the Children's Research Triangle.

Although the staffing within the FHSD is relatively small it is able to impact the quality of health care throughout the state due to its ability to contract with community health centers and private health care providers for the provision of direct medical services. All contracts must respond to a core set of objectives and report on the impact of services within their respective communities. Also through the scope of work outlined within the contracts, FHSD requires specific screenings and adherence to standards of care.

STATUTORY AUTHORITY
FHSD falls within the purview of Title 19 Chapter 321 of the Hawaii Revised Statues SS321-31 Functions of the Department under Part II Preventive Medicine defines the functions of the Department of Health. The powers, duties, and functions of the department of health relating to preventive medicine shall be as follows:
1. To supervise and coordinate activities in the field of preventive medicine, including… crippled children… maternal and child health… nutrition…;
2. To formulate… Programs for the purposed of preventing and reducing disease and disability;
3. To engage in the collection and analysis of statistical information pertinent to any of its activities;
4. To cooperate with and propose methods and programs to other governmental agencies relating to the field of preventive medicine;
5. To serve as the coordinating agency for programs which provide for a range of child abuse and neglect prevention services in relation to assess needs… and to coordinate the prevention programs with child abuse and neglect treatment services….

There are additional statutes which govern specific program activities within the division. Relative to Primary Care HRS SS 321-1.5 Primary health care incentive program allows for needs assessment and the development of strategies to meet the health needs of the medically underserved.

Children with Special Health Needs have several statutes governing it various programs:
HRS SS 321-51-54 Children with Special Health Needs describes its power, duties and activities;
HRS SS 321-291 defines the scope of the Newborn Metabolic Screening Program;
HRS SS 321-351 to 357 Infants and Toddlers defines the eligibility and scope of the Part C Early Intervention Program;
HRS SS 321-361 to 363 defines the scope of the Statewide Newborn Hearing Screening Program;
HRS SS 321-421 to 426 defines the scope of the Birth Defects Program;
HRS SS 321-101 provides authority for Systematic Hearing and Vision Program.

Maternal and Child Health have the following statutes which govern part of its function and activities:
HRS SS 321-1.3 established and defines the scope of the Domestic Violence Special Fund;
HRS SS 321-36 to 38 defines the scope of Child Abuse and Neglect Prevention;
HRS SS 321-321 to 326 establishes the scope of the Maternal and Child Health Program;
HRS SS 321-331 defines the scope and authority of the Prenatal Health Program;
HRS SS 321-344 to 346 provides authority for Child Death Review;
HRS SS 321-471-476 provides authority for Domestic Violence Fatality Review;
HRS SS 350B1 to 7 established and defined the scope of the Hawaii Children's Trust Fund.

While there is no statute specific to WIC services, its activities would fall within the scope of Part VII of the Health statue HRS SS 321-81 Nutrition, which allows for nutritional education, evaluation, and contractual services.

CULTURAL COMPETENCY

The DOH has placed a priority on program responsiveness to the needs of Native Hawaiians and Pacific Island populations. Likewise, FHSD has sponsored trainings and workshops for our staff and our provider network regarding the needs of Hawaii's newer immigrants and have encouraged the spread of best practice for this population. Contracts with the network of community health centers specifically call for the linguistically and culturally appropriate approaches to the division's client base. Presentations at national conferences and the publication of articles regarding promising practices have helped to increase cultural competency within our state.

Hawaii's diversity allows FHSD to include representation from various community and ethnic stakeholder groups on various advisory councils. The Big Island Healthy Start Disparities federal grant has a clear objective to include consumer input in the design of the program, and to include the women from Hawaiian, Pacific Islanders, Hispanic, and Filipino cultures to be active members of its community consortia to improve the system of care for the island of Hawaii.

Collection and dissemination of data analysis specific to the many ethnic groupings within Hawaii have helped to identify needs and behavioral risk of the unique peoples of Hawaii. FHSD has collaborated with the Office of Health Equity to produce a document on the health care needs of Native Hawaiians and Pacific Islanders.

Parent involvement has been a cornerstone for FHSD's Children with Special Health Needs Program. This includes participation in needs assessment, advisory council and informing program design. More recently through the efforts of the Early Childhood Coordinating Systems grant we have placed and emphasis on parent involvement through hosting and promoting "parent café'" sessions.

PROGRAM CAPACITY

The three branches of Family Health Services Division (FHSD) target all three major Title V populations: infants and mothers, children and youth, and children with special health care needs.

The following is a brief description of the basic role of the Director's Office, the three branches, the District Health Offices on the neighbor islands, and FHSD planning, evaluation, data analysis capabilities.

DIVISION CHIEF'S OFFICE

The Office of the Division Chief is responsible for overall management, administration, and direction of the Division. Included in this are activities of program planning, development, evaluation, coordination, research, and information technology support. The Division also houses Don Hayes, M.D., M.P.H., the Centers for Disease Control-assigned MCH epidemiologist.

The Title V Director's Office oversees coordination for the Office of Primary Care, Title V, the State Systems Development Initiative, and the Early Childhood Comprehensive Systems (ECCS) grants. The Division lost its state-fund Fetal Alcohol Spectrum Disorder (FASD) coordinator position due to a statewide reduction in force (RIF); however, was able to maintain this function utilizing a CSHN Branch position.

The attached chart shows the staff and functions under the Division Chief. The seven positions funded with federal Title V funds are identified on the chart and includes the Branch Chief for CSHN.

CHILDREN WITH SPECIAL HEALTH NEEDS BRANCH (CSHNB)

The Children with Special Health Needs Branch promotes integrated systems of care that assure that children and youth with special health care needs will reach optimal health, growth, and development. CSHNB programs include Newborn Hearing Screening, Newborn Metabolic Screening, Children with Special Health Needs, Early Intervention, Genetics, and Birth Defects Programs. CSHNB works to improve access for CSHCN to a coordinated system of family-centered health care services and improve their outcomes, through systems development, assessment, assurance, education, collaborative partnerships, and supporting families to meet their health and developmental needs. Direct and enabling services are provided as mandated by law, as a safety net for CSHCN/families who have no other services, and to improve access of CSHCN to needed health care services. CSHNB now has 151 FTE time positions, of which 12 are Title V funded. The total number decreased due to loss of 53 positions that were abolished or eliminated as a result of the statewide Reduction in Force (RIF) process in late 2009, which also forced closure of the Preschool Developmental Screening Program and Wahiawa and Kona Early Childhood Services Programs.

MATERNAL AND CHILD HEALTH BRANCH (MCHB)

The Maternal and Child Health Branch is now comprised of approximately 39.5 FTEs, of which 15.5 are Title V funded, 7 are state funded and 17 are funded by other federal sources. The total number decreased due to the loss of 13 positions that were abolished or eliminated as a result of the RIF process in late 2009. Additionally 1 Title V position and 1 TANF position were eliminated due to budgetary restrictions. The Branch strives to promote and protect the health and well-being of mothers, infants and children and their families in the context of the communities in which they live. The Branch is divided into three major programmatic areas: Women's Health Section (which administers the federal Title X family planning program); Family and Community Support Section and an Administrative Section comprised of fiscal and data units. Due to the RIFs, the branch lost its Children & Youth Wellness Section and is currently reviewing its administrative organization for possible revision. The MCH Branch oversees a network of non-profit and private providers with contracts for direct, enabling, and population-based services focused on women and their families. Program staff work collaboratively with community partners to provide leadership and support for core public health functions in the State. Strategies include needs assessment, system development, mobilization of community partners and coalitions, surveillance of health status and utilization, and support of best and promising practices to enhance service delivery and build community capacity. The Branch continues to support a broad mandate with limited infrastructure.

SPECIAL SUPPLEMENTAL NUTRITION PROGRAM FOR WOMEN, INFANTS, & CHILDREN (WIC)

The Special Supplemental Nutrition Program for Women, Infants & Children (WIC) is a federally funded short-term intervention program designed to establish good nutrition and health behaviors through nutrition education, breastfeeding promotion, a monthly food prescription allotment and access to maternal, prenatal and pediatric health-care services. WIC serves low-income pregnant and post-partum women and children up to age 5 nutritionally at-risk through purchase-of-service (POS) and state-run agencies. WIC contracts with seven community health centers, one Native Hawaiian Health Care Center and one hospital to provide services, resulting in greater integrated health service delivery than the eight state-run agencies. During FFY 2009, Hawaii WIC served a monthly average of 36,320 individuals, an increase of 6.7% from 34,050 individuals in 2008. The mix is approximately 25% women, 25% infants and 50% children. The new WIC food packages effective October 2009 (with reduced fat milk, fruits/vegetables, whole grains, baby foods and soy alternatives) aligns with messages to increase intake of fruits/vegetables and whole grains/fiber, decrease intake of fat and juices, and breastfeed babies. The gradual change to a more paraprofessional delivery model continues as does the emphasis on participant-centered services. Over 12% of the trained state WIC staff (14 of the 113.5 FTEs) was replaced in some cases with higher salaried more senior staff during the 2009 RIF process; further vacancies exist

for qualified nutritionists due to two hiring freezes. Some POS agencies have accepted additional caseload and funds, but furloughs for state employees have impacted potential caseload and spending. ARRA funding will be used to plan the replacement of the 11-year old information technology system.

DISTRICT HEALTH OFFICES

Administration of all Department of Health programs on the neighbor islands are provided by the three District Health Offices (DHO) located on the islands of Kauaʻi, Maui and Hawaii and follow political county jurisdictions. Kauaʻi DHO is also responsible for the island of Niʻihau. Maui DHO is responsible for the islands of Lanaʻi and Molokaʻi. Each DHO has a Registered Nurse with public health experience, who functions as the FHSD Coordinator responsible for the administration of FHSD programs: CSHN (including Early Intervention Services), Maternal and Child health. Maui and Kaua`i coordinators also oversee WIC, while Hawaii island WIC oversight is managed within the WIC program. Each office may also administer grants specifically designed to target the needs of their rural island communities.

Coordinators have also been active in DHO initiatives such as School Flu Clinics and disaster preparedness activities. Coordinators and other FHSD staff have been involved with the response to the H1N1 outbreak and investigation.

Neighbor Island FHSD Coordinators are uniquely positioned at the community level to ensure coordinated service delivery to consumers. Based on community needs, the Coordinators are responsible for providing all levels of service delivery from Direct to Infrastructure Building Services. Neighbor Island Coordinators and EIS staff are also closely involved with building the system of service delivery for State Department of Education Special Education programs under IDEA. This is not the case for the Division offices on Oʻahu. On Oʻahu, programs for school age children under IDEA are coordinated largely between the Department of Health's Child and Adolescent Mental Health Division and the State Department of Education.

Each Neighbor Island FHSD office is organized somewhat differently. The FHSD Coordinators often oversee many other District Health Office functions and responsibilities for other health areas.

HAWAII COUNTY

The FHSD Neighbor Island Coordinator responsibilities on the Island of Hawaii are handled by a Nurse Manager for Special Services, Maylyn Tallett. She provides supervision and support for Title V programs which include the Children with Special Health Needs Program (1 social worker in East Hawaii; 1 social worker and 1 half-time office assistant in West Hawaii); Early Intervention Program (2 social workers in East Hawaii); Maternal and Child Support Services Program (1 RN and 1 office assistant in East Hawaii); Special Services Administration (1 office assistant), and Administrative supervision for the Office of Health Care Assurance Program (1 RN).

Due to RIFs in late 2009 the Kona Early Intervention Services Program was closed (11 positions total). Two positions for the Children with Special Health Needs Program were eliminated (1 early intervention specialist in East Hawaii and 1 half-time office assistant position). In the Maternal and Child Support Services Program 2 positions were lost (1 RN in West Hawaii and 1 social worker in East Hawaii). Additional supervision is provided to the Office of Health Care Assurance Program staff located within the HDHO.

The Maternal and Child Support Services Program provides on-island oversight of purchase of services (POS) contractors, participates in local area consortia activities, and engages in administrative functions for the Healthy Start Initiative: Eliminating Disparities in Perinatal Health -- Big Island Perinatal Health Disparities Project (Project).

In addition to program supervision, the FHSD NI Coordinator is an active participant with

community organizations such as: East Hawaii Coalition for Child Abuse and Neglect Prevention; Family Violence Interagency Committee; Upstream Perinatal Solutions; Hawaii Island Dental Health Task Force; Tri-County Dental Health Task Force; Child Safety Collaborative; Child Death Review Committee; State FASD Committee and Project related activities both administratively and directly with the Local Area Consortia's in Kau, North Hawaii, East Hawaii and West Hawaii.

The Hawaii District Health Office serves an important role in the health and safety of our local residents therefore, must be prepared to serve the community at all times. All FHSD staff participate in disaster preparedness trainings by taking part in un-announced call-downs, attend in-services for designated Bioterrorism Response Teams (BRT). Collaboration with the County level programs and local area agencies are vital to a seamless system of communication for timely notifications of tsunamis, hurricanes, extreme vog conditions, road closures, announcements of out of control fires (exacerbated by severe drought conditions) and earthquake disaster assistance. Also, FHSD programs participate in the annual school flu clinics and other community disaster related exercises. All employees are given the opportunity to undertake leadership roles and supportive functions to increase their knowledge and skills with the State Department's emergency response system.

The major challenge for HDHO is assuring access to services for the county's rural communities given the changing demographics of these areas as new residents move into remote areas of the island. The state reduction in force and the elimination of many family support programs has forced existing programs to reorganize, shift priorities, and encourage increased collaboration among Federal, State, County, and local area agencies to increase efficient delivery of existing services.

MAUI COUNTY (Includes islands Maui, Molokai & Lanai)
The FHSD programs in Maui Tri-Isle County (Maui, Lanai, Molokai) are supervised by a registered nurse, Jeny R. Bissell, who is responsible for the administrative supervision of all FHSD programs and employees, which includes WIC (2 nutritionists, 4 nutrition assistants, 2 nutrition aides, 3 office assistants), Early Intervention (1 social worker), CSHN (1 social worker), MCH (1 registered nurse), and a office assistant. The MCH RN position is approved to start August 2, 2010 after vacancy of 4 months.

Substantial time is devoted toward building a coordinated system of services, in collaboration with the Department of Education, Part C, Part B Agencies, Medical and Dental Providers for children eligible for IDEA services and 504 Special Accommodations; with the Department of Human Services/Maui Child Welfare Services, Maui County Government, Judiciary and their Purchase of Services Contractors for abused and neglected children; with the Maui County 501C-3 Non-Profit Organizations providing family support and family strengthening services; with the Maui Continuum of Care for the Homeless Communities.

Additional duties include special projects related to Title V, FHSD, and/or the Maui District Health Office such as the Injury and Violence Prevention Projects; and, Maui QExA Collaborative Project.

Maui Tri-Isle County have lost programs and services as a result of budget cuts and poor economy. Because of this, public-private collaborative partnerships are more evident. Additionally, informal partnerships with consumers are also evident in many of the activities and efforts to maximize our existing and very limited resources. This is especially true in our efforts to effectively serve our most vulnerable populations. Substantial time is devoted to providing support to my Maui FHSD Staff as they continue to face increasing client caseload and having to serve children and families with multiple stressors and with limited resources.

Maui MCH Coordinator and FHSD Supervisor/Coordinator participated in the first Maui DV Fatality Review in April 2009. The Maui MCH Coordinator continues to chair the CDR process for Maui County and is coordinating the first combined CDR and DV Fatality Review for August 2009.

The FHSD Supervisor/Coordinator and MCH Coordinator continue to help coordinate various projects and initiatives (i.e. FASD Training, capacity building and staff/service providers training, health promotion, cultural competency training, public awareness/education). The FHSD Supervisor/Coordinator supervised the 4th Fall Prevention Project for frail and well elderly.

The FHSD Supervisor/Coordinator are part of a 5 member team selected to participate in the PREVENT (Prevent Violence through Education, Network and Technical Assistant) Institute at the University of North Carolina School of Public Health. Maui was one of 16 National Teams selected to receive training and mobilize a community based effort to prevent child maltreatment. The 6 months project established the Ho'oikaika (To Strengthen) Partnerships with the goal to create a seamless safety net of CAN prevention services for children and their caregivers.

KAUAI COUNTY

The Kauai FHSD programs are supervised by a registered nurse Cashmire Lopez. She provides the administrative supervision and support to all FHSD programs/personnel which include FHSD Secretary, Children With Special Health Needs Program (1 social worker), WIC (1 registered dietitian, 3 nutrition aides, 1 clerk-typist, 1 clerk), Maternal & Child Health (1 nurse coordinator), and Early Intervention Section (2 social workers). Due to budget cuts and reduction in workforce, the FHSD has lost 1 social worker at Early Intervention. The Maternal & Child Health nurse position is currently vacant and therefore, the FHSD program manager is responsible to cover these areas.

The Program Manager is also responsible for several Title V service contracts and grant funded initiatives on the island which includes family planning, perinatal support and HIV/STD prevention services. Other related MCH duties include leadership roles on the Primary Health Care Consortium, (to address health care access and elimination of health disparities), Kauai Dental Health Task Force, Medical Home Initiative, Kauai Drug Task Force, Kauai Community Children's Council (partnership for IDEA children's services), Mokihana Project (partnership with DOE and Child & Adolescent Mental Health for coordinated school-based mental health services), Good Beginnings Alliance Kauai (integrating child care and early preschool into the broader community system of services and supports for young children and their families), Tobacco Free Kauai Coalition (to decrease smoking during pregnancy), Get Fit Kauai Coalition (promoting physical activities and good nutrition), and Kauai Domestic Violence Task Force (reduce violence and sexual abuse in adults & children).

The FHSD Coordinator is also involved in managing the Kauai Rural Health Association and the Hawaii State Rural Health Association (to improve the network of health services to assure responsiveness to community needs). The Coordinator also participates in the Tri-county Dental Task Force (to raise the level of oral wellness in the community and improve oral health of children) and Kauai Children's Justice Center Interagency Council (development of interagency agreements to address needs of Children of Abuse and Neglect and protect health and safety of women, children and youth).

The Coordinator serves on the Hawaii State Rural Health Association Board of Directors which assures the network of health services is responsive to the needs of people living in rural areas of Hawaii. Board members advise on health policy and allocation of resources. The Coordinator is also involved with a new initiative to establish a Statewide Sexual Assault Response network to ensure services to sexual assault victims are responsive, effective, and forensically sound.

Additional collaborative initiatives on Kauai include SNAPed (Nutrition and Physical education) a food stamp nutrition education project and a recently awarded American Recovery and Reinvestment Act (ARRA) grant pertaining to obesity prevention, which will include hiring a full-time Breastfeeding Coordinator for Kauai WIC to promote and encourage breastfeeding and breastfeeding friendly hospitals on the island of Kauai.

CONTRACTED SERVICES
The Hawaii health delivery system depends on public-private partnerships for the delivery of all services, including MCH services. The vast majority of community prevention, primary care and specialty services are provided by private health care providers and community-based non-profit organizations. FHSD contracts with a wide range of these providers (both public and private), using a competitive bid process for most of its community-based services. Nearly 150 purchase of service contracts, memorandum of agreements and fee for service contracts were executed in state fiscal year 2009 totaling nearly $40.5 million to deliver direct, enabling, population based and infrastructure building services to the MCH population.
An attachment is included in this section.

C. Organizational Structure

TThe Department of Health (DOH) is one of the major administrative agencies of state government with the Director of Health reporting directly to the Governor (see attached chart). DOH works with the Governor-appointed Board of Health to set state public health policies. The DOH is divided into 3 major administrations (see attached chart), one of which is the Health Resources Administration (HRA). There are 6 major divisions within HRA including the Family Health Services Division (FHSD), which is responsible for the administration of all Title V funding. The Children with Special Health Needs Branch, Maternal and Child Health Branch and WIC Services Branch is part of FHSD.

The Governor appoints all state department directors and deputy directors. Governor Linda Lingle was elected in 2001 and is currently ending her second and final term as Governor as mandated by state term limits. Dr. Chiyome Fukino, M.D. is the current Director of Health and has been in that position since 2001. Michelle R. Hill is Behavioral Health Deputy; Ms. Susan Jackson is the Administrative Deputy, and Laurence K. Lau, Esq. is the Environmental Health Deputy. The HRA deputy position has been vacant since February 2009. Dr. Fukino and Ms. Jackson have shared supervision responsibility for HRA. FHSD has been under the supervision of Ms. Jackson since June 2009.

D. Other MCH Capacity

There are approximately 380 full-time equivalent employees in FHSD. This includes temporary and permanent positions. Of the total, roughly 27 FTEs are funded using federal Title V monies (5.5 at Division level, 8.5 at CSHN Branch and 13 at MCH Branch). Most of the Title V funded positions have been created to build the Division/Branch level infrastructure capacity.

Approximately 67 FTEs are based in the three district health offices on the neighbor islands: 37 FTE on Hawaii island, 12 on Kauai and 18 on Maui.

Epidemiology, planning and data personnel are located throughout the Division. The One epidemiologist position is located at the MCH Branch. Currently, a CDC-assigned epidemiologist works at the Division level. Plans are underway to establish another epidemiologist position at the Division level. There are a total of 7 research statisticians at the Division level and at the MCH and CSHN branches; 5 planner/program specialists at the Division and MCHB; and 13 data processing staff at the Division and at WIC and CSHNB.

The State budget has been a deficit situation for several years. The Department of Health experienced a Reduction in Force in October 2009. This resulted in the abolishment of 319 positions department wide; and 58 positions within FHSD. Over the last three years there has been a concerted effort by Governor Lingle to downsize state government. Her goal was to eliminate 1,000 positions statewide; to date 817 positions have been abolished; this in addition to

the deletion of many vacant positions. To avoid further layoffs, government workers have been furloughed two days a month in the administrative, judiciary and educational segments from October 2009 through June 30, 2011. The University of Hawaii staff accepted a 6.7% cut in pay; to be reinstated after two years. The greatest controversy has been the furloughing of public school teachers and support staff, resulting in Hawaii having the lowest number of school days per year in the nation.

Due to anticipated State budget deficits the program has been under a periodic hiring freeze despite pending vacant positions. All federally funded positions have been approved for hire by the Governor. Most State general funded positions which are approved for filling are those which are under court mandates, i.e. Early Intervention Services and Healthy Start. The Division is aggressive in its attempts to seek private foundation and federal grants to continue to advance the goals and objectives of Title V.

The Fiscal Year 2010-2011 administrative budget proposed additional restrictions to health and human services programs. The Hawaii State Legislature has appropriated more than $23M of Emergency and Budget Reserve Fund to restore partial services which impact vulnerable populations including the elderly and children. Healthy Start Home Visitation program was appropriated $1.5M of these reserve (Rainy Day) funds and $1.6M of TANF funding. "Rainy Day" funds were also appropriated to Waianae Coast Comprehensive Health Care Emergency Room, Kokua Kalihi Valley Comprehensive Family Services, and Hawaii Medical Services Association to restore the Keiki Care program. In addition the Legislature set aside $67 M of the Hurricane Relief Funds to end furloughs for the 2011 School Year. The Governor has until the middle of June to veto any part of the Legislative Budget.

Brief biographical information on the FHSD senior level management staff is presented.

LORETTA FUDDY, FHSD Division Chief
Ms. Loretta Fuddy holds degrees in sociology, social work, and public health from the University of Hawaii. She is currently the Chief of Family Health Services Division, serving in this position for eight years. Two years prior, she served as DOH Deputy for Administration. Her area of expertise for thirty-five years has been in the promotion of health and social services for women and children through the State of Hawaii. Ms. Fuddy has made numerous national and international professional presentations regarding the subject of maternal and child health prevention programs. She serves as clinical faculty for the University of Hawaii Department of Public Health and School of Social Work. She serves as a health consultant to Hawaii's efforts to reform and improve its child protective services. She is also a board member for the March of Dimes, Chapter of the Pacific, the Hawaii Children's Trust Fund, and Hawaii Early Learning Council. She has been a member of the Association for Maternal and Child Health Programs Executive Committee since 2006, currently serving as Secretary and is a member of AMCHP's Work Force Development and Emerging Issues Committees.

DR. PATRICIA HEU, Children with Special Health Needs Branch Chief
Dr. Patricia Heu, MD, MPH, is a pediatrician and has served as the Children with Special Health Needs Branch Chief since 1997. She received her medical degree from the University of California San Francisco and her degree in public health from the University of Hawai‘i. She completed her pediatric residency with the University of Hawaii/School of Medicine/Department of Pediatrics. Her prior DOH experience includes Medical Consultant to the Maternal and Child Health and School Health Services Branches, and Clinic Pediatrician and Clinical Director for the Waimanalo Children and Youth Project (serving a rural community on the island of Oahu). She serves on numerous advisory bodies and committees concerning CSHCN.

BARBARA YAMASHITA, Maternal and Child Health Branch Chief
Barbara Yamashita, MSW, has over 30 years of experience in health care, social services and public health providing direct services as well as in leadership positions. Ms. Yamashita served as hospital administrator, worked in the area of child abuse and neglect and youth services, and

has both private non profit as well as government experience. At the Hawaii Department of Health, Ms. Yamashita was Chief of the Community Health Division which included the chronic disease programs and public health nursing; she also served as the Chief of the Preventive Health Services Branch and was a section supervisor of perinatal services. Ms. Yamashita attended graduate school on a Maternal and Child Health stipend.

LINDA CHOCK, WIC Services Branch Chief
Linda Chock, MPH, RD has served as WIC Director and Chief, WIC Services Branch since 2002. She previously served as the WIC Clinic Operations Section Chief since 1997. She holds a BS in Food Science & Human Nutrition and a MPH in Public Health Nutrition, both from the University of Hawaii. Her 34 years of experience includes clinical and administrative dietetic work at both private and public hospitals, public health nutrition education, and nutrition program planning and management at federal, state and regional levels of government. She worked in Texas, California and Missouri before returning to practice in Hawaii.

DR. LOUISE IWAISHI, Medical Director
Dr. Iwaishi is currently Medical Director for the Family Health Services Division. She had been in private pediatric practice in a multispecialty group for 10 years before joining the faculty of the University of Hawaii John A. Burns School of Medicine (JABSOM) in 1991. As assistant professor in the Department of Pediatrics, her focus has been residency training in primary care and developmental pediatrics. She is Director of the Hawaii Maternal Child Health Leadership Education in Neurodevelopmental Disabilities program (graduate level interdisciplinary training) and the Community Pediatrics Institute (pediatric residency training in child health and Medical Home advocacy). She studied Zoology at Pomona College in California, received her M.D. from the University of Hawaii, JABSOM and completed her pediatric residency training at Kapiolani Medical Center for Women and Children's pediatric integrated residency program. Dr. Iwaishi is a past president and continues to be on the Board of the American Academy of Pediatrics-Hawaii Chapter where she advocates for child health issues related to Title V and AAP initiatives (e.g. Family Voices, Early Intervention Screening/Referral, Medical Home community resources and EPSDT services).

PARENT INVOLVEMENT IN CHILDREN WITH SPECIAL NEEDS PROGRAMS
The Children with Special Needs Branch programs involve families in various ways, including councils, task forces, and advisory committees; development and review of educational materials; participation in presentations and panels; participation in conferences and training sessions; interview panels for staff positions; advocacy for legislation; and input on proposed changes for policies and procedures. Parents are compensated or assisted in various ways including stipends; airline coupons and ground transportation for Neighbor Island families; and child care during activities. Family participants are of diverse ethnic and cultural backgrounds.

E. State Agency Coordination

DEPARTMENT OF HEALTH
Within the Department of Health, Title V works with the neighbor island District Health Offices and various Divisions/programs including the Healthy Hawaii Initiative (the department's chronic disease management prevention program), Developmental Disabilities, Child and Adolescent Mental Health, Alcohol and Drug Abuse, Disease Outbreak and Control, Emergency Medical Services/Injury Prevention and Control Program, Public Health Nursing, Dental Health, Office of Health Status Monitoring (vital statistics), the State Health Planning Agency as well as the Environmental Health Administration.

The State Primary Care Office (PCO) is located within the Title V agency and works in partnership with public, private and voluntary organizations that are committed to the medically underserved in the State including, the Hawaii Primary Care Association, the Hawaii Area Health Education Center, the Native Hawaiian Health organizations, the Native Hawaiian Scholarship

Program, the Hawaii Dental Association, neighbor island District Health Offices, and other state agencies.

DEPARTMENT OF EDUCATION
Hawaii has a single unified public school system serving kindergarten to grade 12. Over 182,000 students are enrolled in public schools, roughly 84% of all students enrolled in educational institutions.

Efforts to promote healthy habits among students and school staff fall under the direction of a new Board of Education policy known as the Wellness Guidelines which requires each school to develop policies and practices to improve nutrition and promote physical activity. The Department's Healthy Hawaii Initiative is the liaison with DOE on the School Wellness Initiative.

CSHNB/Early Intervention Section (EIS) works collaboratively with the DOE in several areas:
- EIS and DOE develop transition materials and regularly provide joint training to early interventionists, DOE staff, families, and other community members.
- Depending on the availability of funds, EIS supports the continuation of early intervention services for DOE-eligible children with Autism Spectrum Disorder who turn 3 during the summer months until their DOE school year starts.
- The State Interagency Quality Assurance Committee provides oversight and leadership for the quality assurance system that monitors the quality and effectiveness of services for children and youth with special needs. Members include the DOE, DOH (Family Health Services Division, EIS, Child and Adolescent Mental Health Division, Developmental Disabilities Division, and Alcohol and Substance Abuse Division), DHS, Family Court, and Hawai‘i Families as Allies.

WIC serves with representatives from the DOE's Office of Hawaii Child Nutrition Programs (OHCNP) on a variety of committees. WIC works with the DOE School Food Services to coordinate the amount of formula provided by DOE versus WIC.

DEPARTMENT OF HUMAN SERVICES
DHS houses programs critical to the health and welfare of the state MCH population including Medicaid EPSDT, Temporary Assistance to Needy Families (TANF), Food Stamps, Child Welfare Services, Disability Determination, Vocational Rehabilitation, Child Care Services, and Youth Services Programs.

DHS Med-QUEST Division (MQD) provides reimbursement to DOH for early intervention services for QUEST-eligible infants and toddlers who are developmentally delayed or biologically at risk.

MQD has updated the EPSDT examination form, which includes immunizations, screening, referrals, and care coordination needs. The standardized form provides providers with clear guidelines about the required examination components, and provides information on screenings and immunizations by various ages. The Family Health Services Division provided input to DHS on this form. MQD is assuring diverse community participation and expert advising regarding EPSDT through methods such topical meetings with specific stakeholders.

The DHS also experienced a reduction in workforce and the EPSDT Coordinator position was vacated. The MCHB will follow up with the new coordinator and explore ways to partner on an as needed basis.

DHS Benefit, Employment and Support Services Division (BESSD) provides funding for Healthy Child Care Hawaii to the UH Department of Pediatrics. This collaborative project also involves the American Academy of Pediatrics-Hawaii Chapter and CSHNB. The project promotes the health and safety of young children in child care, based on the national health and safety performance standards in child care settings.

DHS Vocational Rehabilitation and Services for the Blind Division (DVR) is a state-federal

program for individuals with disabilities which provides vocational rehabilitation services to enable eligible individuals with disabilities to achieve gainful employment and economic self-sufficiency. The Children with Special Health Needs Program refers clients as necessary for DVR services. CSHNB participated in the DVR needs assessment.

DHS Disability Determination Branch (DDB) which is part of DVR, determines whether Hawaii applicants for SSI disability benefits meet the required medical and/or psychiatric/psychological and vocational criteria to be found disabled. DDB refers children under age 16 years with disabilities who are medically eligible for Supplemental Security Income (SSI) to the Children with Special Health Needs Program (CSHNP). CSHNP provides outreach, assessment, information/referral, and/or service coordination as needed, regarding the SSI beneficiary's medical, education, and social needs.

MCHB collaboration with DHS programs includes child welfare/safety issues through projects like the Blueprint for Change, Title IVB Advisory groups, the Community Based Child Abuse Prevention Program (CBCAP) and the Child Death Review. Due to the state RIF, MCHB is evaluating its current collaboration efforts to determine how best to utilize remaining staff and partnerships to achieve the desired outcomes for children and families.

Families that qualify for DHS services (the Supplemental Nutrition Assistance Program, formerly known as Food Stamp Program, TANF and Medicaid) are automatically income eligible for WIC. The agencies work closely to ensure clients receive information and assistance to apply for available services. DHS allows WIC limited computer access to the DHS enrollment system to check on adjunctive income eligibility for WIC applicants.

EXAMPLES OF PUBLIC AND PRIVATE COLLABORATION

Hawaii Early Intervention Coordinating Council (HEICC) advises the Director of Health on issues related to the planning, implementation, evaluation, and monitoring of the statewide system of early intervention services, and assists the DOH in achieving the full participation, coordination, and cooperation of all appropriate public agencies in the state. Members are appointed by the Governor and include parents of children with special needs, early intervention providers, state legislators, and representatives for personnel preparation, special education preschool services, Medicaid program, Office of the Governor, provision/payment of early intervention services, Head Start/Early Head Start, child care, foster care, regulation of health insurance, education of homeless children, children's mental health, family advocacy, military, and community preschools.

Newborn Metabolic Screening Advisory Committee consists of consumers and professionals from the private and public sectors, including physicians, laboratory personnel, nurses from various birthing facilities, medical insurance plan representatives, parents, and other DOH representatives. The committee's purpose is to provide support, guidance, and feedback to DOH about newborn screening; disseminate information about newborn screening to colleagues and the community; monitor accountability and quality of the newborn screening program; and discuss ideas and issues relevant to newborn screening.

Hawaii Birth Defects Program (HBDP) Advisory Committee is composed of representatives from the community, medical, university, and public and private sectors.

Early Hearing Detection and Intervention (EHDI) Advisory Committee advises the DOH Newborn Hearing Screening Program and its Baby Hearing Evaluation and Access to Resources and Services Project (Baby HEARS). The committee includes parents, AAP-Hawaii Chapter EHDI Champion, Hospital Newborn Hearing Screening Coordinator, DOH (EIS, Genetics Program, Newborn Metabolic Screening Program, and CSHNB Chief and Research Statistician), March of Dimes-Hawaii Chapter, Gallaudet University Regional Center, and pediatric audiologists.

State Genetics Advisory Committee consists of representatives from public health, health care organizations, consumers, laboratories, insurance, policy makers, and other interested organizations such as the March of Dimes. The Committee advises the DOH about genetics activities and helps disseminate information about these activities.

Hawaii Community Genetics (HCG) is a partnership of DOH/CSHNB Genetics Program, Kapiolani Medical Center for Women and Children, Queen's Medical Center, and UH School of Medicine to develop clinical genetics and metabolic services in Hawai‘i. HCG has a full-time geneticist for clinical services. Clinical genetics services are provided statewide with regular in-person Neighbor Island clinics and telemedicine visits. HCG also provides clinical and newborn screening follow-up services for Guam.

A core team of CSHNB, Family Voices (with the Hilopa‘a Family to Family Health Information Center), UH/School of Medicine/Department of Pediatrics (with the Maternal and Child Health Leadership Education in Neurodevelopmental and Related Disabilities), and American Academy of Pediatrics-Hawaii Chapter, with other key state/community partners, continues to work closely together in various areas toward achieving the six core outcomes for CSHCN.

The FHSD Medical Director is the Title V representative on the State Council on Developmental Disabilities. Act 175 of the 2001 Legislature required that the Council's membership include a Title V representative. The Council's responsibilities include: development of the state plan which guides the development and delivery of services for persons with developmental disabilities, coordination of departments and private agencies, evaluation, and advocacy.

The Special Education Advisory Council is an advisory committee to the Superintendent of Education for policies regarding the education of students with disabilities. Membership includes representative of consumer advocate groups, parents, individuals with disabilities, regular and special education personnel, DOH, DHS, and UH. EIS is a representative on SEAC.

The Early Childhood Comprehensive System (ECCS) Strategic Management Team (SMT) consists of public and private representatives charged with improving the system of early childhood services in the state. With a grant from the federal MCH Bureau, an assessment of the service system was completed and a strategic plan developed. The SMT provides leadership for the plan's implementation. Members include representatives from Departments of Education, Health, and Human Services, Department of Housing and Urban Development, Aloha United Way, American Academy of Pediatrics, Community Health Centers, Child Care Resource and Referral Agency, Good Beginnings Alliance, Hawaii Association for the Education of Young Children, Native Hawaiian Early Childhood Agencies, and parents.

Hawaii State Child Death Review Council is a voluntary public-private partnership formulated in 1996 through the leadership of Title V to establish a comprehensive, statewide, multidisciplinary child death review system to reduce preventable child deaths from birth to age 18. In 1997, state statute authorized the DOH to conduct child death reviews. The Child Death Review Council, with broad representation from the private and public sector, oversees the development and implementation of CDR.

Domestic Violence Fatality Review Council is a multidisciplinary and multiagency group of representatives from the public and private agencies which was legislated in 2006 to reduce the incidence of preventable deaths related to domestic violence. The DOH is the lead agency to administer statewide team reviews, to establish a surveillance system, to recommend changes in policy, organizational practice, community-based education, and interagency services, and to provide training opportunities.

Hawaii Children's Trust Fund (HCTF) was established by statute in 1993 to support family strengthening programs aimed at preventing child abuse and neglect and promoting healthy child development. HCTF is comprised of a coalition of parents, public and private agency personnel

with an Advisory Committee and Board. The endowment fund consists of three streams of funding: federal funding from the Community-Based Child Abuse Prevention program (CBCAP), private donor contributions, and monies received from a tax check-off program.

Keiki Injury Prevention Coalition (KIPC) is an organization of over 60 private and public partners in the community, including neighbor island chapters. Title V staff participate in statewide activities to address issues related to childhood injury prevention. The Safe Sleep Committee, under the leadership of Title V staff, develops community-based prevention strategies. Title V is also active on the Suicide Prevention Steering Committee. KIPC supports networking with agencies and community organizations to effect legislation, policy, and educational measures to reduce injuries.

Hawaii Suicide Prevention Task Force (SPTF) was formed in 2005 and is staffed by the DOH Injury Prevention Program. The Steering Committee serves as an advisory group to the DOH and works on implementing the goals and objectives for suicide prevention in the Hawaii Injury Prevention Plan. The SPTF consists of over 50 multi-disciplined, public and private agency members interested in suicide prevention. Members include the DOE, Honolulu Police Department's (HPD), the University of Hawaii, the Title V agency, DOH Child and Adult Mental Health Divisions, Emergency Medical Services (EMS) and others.

Child Safety Collaborative (CSC) is a public-private partnership to promote a safe and nurturing environment for children and youth. The group has defined "safe" to mean: free from environmental, physical, and emotional harm. The group works towards creating a child safety system that is coordinated, effective, and well-funded through public awareness, education, advocacy, and action. Primary partners include: Blueprint for Change, Department of Human Services, Good Beginnings Alliance, Hawaii Children's Trust Fund, Keiki Injury Prevention Coalition, Prevent Child Abuse Hawaii.

Child Abuse Prevention Planning (CAPP) Council is a public-private partnership that develops statewide public awareness events for the annual Child Abuse Prevention Month. Council members meet monthly and are represented by a broad spectrum of family strengthening and prevention organizations including all branches of the armed services. Council members develop a media campaign to share information about Child Abuse Prevention Month events.

Injury and Violence Prevention Cross-Program Integration Project is a joint effort between Hawaii DOH MCH Branch, Injury Prevention program and the Children's Safety Network (CSN). This 3 year pilot project will develop a toolkit and staff training to assist state MCH programs to effectively integrate injury prevention into their services. CSN is providing technical assistance and training for the project with a focus on prevention of child maltreatment and bullying.

Hawaii Partnerships to Prevent Underage Drinking (HPPUD) Coalition was created to coordinate efforts to address the problem of underage drinking in Hawaii. The members of the partnership represent county, state, and federal agencies, non-profit organizations, private businesses, and community residents concerned with the health of Hawaii's youth. The current structure of HPPUD includes a Statewide Advisory Council, and four county coalitions. HPPUD's Strategic Plan was completed in 2009.

Hawaii Perinatal Consortium (HPC) is a statewide leaders' forum organized to share information and data, define the unique needs of our state, and promote strategies to improve perinatal health. The HPC utilizes members' expertise to advance changes in health policy and public awareness through interaction with government, corporate, and community decision makers. HPC is an advisory group for policy development to interface with related coalitions and groups involved in perinatal health, provides a bridge for newly emerging issues, and assists organizations in data collection and presentation.

Healthy Mothers, Healthy Babies Coalition of Hawaii (HMHB) is a nonprofit agency and part of a

national network of organizations and individuals committed to improving maternal, child and family health through collaborative efforts in public education, advocacy, and collaboration. HMHB distributes educational materials for pregnant women and provides leadership for advocacy efforts by convening quarterly meetings of perinatal providers, disseminating regular news updates, and advocating for the adoption of important statutes and policies affecting perinatal health. HMHB oversees the Title V MothersCare toll-free statewide hotline for information and referrals to prenatal care. HMHB also maintains a website that provides prenatal information and referral.

Healthy Youth Hawaii (HYH) is a state-wide coalition of leaders who share a concern about teen pregnancy. The HYH mission is "creating networks and promoting effective programs for Hawaii's youth that support healthy and informed choices." A primary goal is to actively promote the use of science-based, proven effective, and culturally appropriate teen pregnancy/STI/HIV prevention and sexuality health education programs for Hawaii youth. The Title X Family Planning Health Educator and the State Adolescent Health Coordinator of MCHB participate on this coalition.

Hawaii HIV/AIDS Community Planning Group (CPG) is a partnership between state health departments and community members who are infected with and affected by HIV. The primary task of the CPG is to work with the state health department to develop a Comprehensive HIV Prevention and Care Plan that is based on scientific evidence and community needs. The MCHB Title X Family Planning Health Educator is an elected member of this group.

Hawaii Women's Health Week Committee was established in 2006 to promote the importance of preventive screening and check-ups for women during Hawaii and National Women's Health Week and during the year. The Committee is comprised of Hawaii Department of Health, Kapiolani Women's Center; Healthy Mothers Healthy Babies Coalition of Hawaii; Hawaii Commission on the Status of Women; Women's Fund of Hawaii; American College of Obstetricians and Gynecology Hawaii Section; Planned Parenthood of Hawaii; and health care plans including Hawaii Medical Service Association, AlohaCare, The Queens Women's Health Center; and Kaiser Permanente. The Committee annually updates and distributes a screening guide and promotes other actions to increase preventive screening and check-ups for women statewide.

Adolescent Chlamydia Workgroup was established in 2004 to address this State priority and decrease Chlamydia rates for Hawaii youth. Public and private entities including the Department of Health, American College of Obstetricians and Gynecology and health plans Hawaii Medical Service Association, AlohaCare and UHAA are now focused on promoting strategies for increased screening and treatment of Chlamydia including partner management, and improving surveillance and data collection systems to support accurate reporting.

The USDA-FNS Hawaii Council is comprised of the U.S. Department of Agriculture (USDA) Field Office and USDA-funded State agencies (DOH WIC Program, Department of Labor & Industrial Relations Office of Consumer Services, DHS SNAP, University of Hawaii's Cooperative Extension Service and DOE OHCHP. A memorandum of agreement supports collaboration between agencies to share goals and activities, implement culturally appropriate nutrition education materials and share resources.

The Hawaii Head Start-State Collaboration Project Advisory Council's mission is to assist the State of Hawaii in improving life outcomes and opportunities for Head Start-eligible families. The DOE, DHS, and the WIC Program are represented on the council. The seven priority areas of collaboration are: health care, welfare, child care, education, national service activities, family literacy services, and activities relating to children with disabilities.

The State Nutrition and Physical Activity Coalition (NPAC) was established to implement the State Nutrition & Physical Activity Plan. There are also neighbor island coalitions supporting the DOH Healthy Hawaii initiative. The NPAC State Director is housed at the University School of

Medicine. Several members of the Division are active in subcommittees addressing nutrition, school health, health services, workplace health, and the built environment.

Hawaii Immunization Coalition is a statewide, community-based coalition of public and private agencies, which ensures that all of Hawaii's residents are appropriately immunized against vaccine-preventable diseases. Activities include sharing information and resources, educational materials, policy development, and training for health professionals/organizations on current immunization information. Immunization practices to address access issues and barriers for at-risk populations and data information systems continue to be priorities.

The Kona WIC Oral Health Project slated for Summer 2010 is a collaboration between the DOH Kona WIC Program, the West Hawaii Community Health Center and the Dental Health Foundation to increase accessibility to oral health services. WIC families will have oral screening, fluoride varnishes and education.

The University of Hawaii MCH Program, Department of Public Health, offered an MCH Certificate Program with federal MCH Bureau funding to provide training in data analysis and data-based program management. Several Title V agency staff have graduated from the certificate program. The MCH certificate program did not receive continued funding from MCHB, which will result in the closure of the only MCH public health training program in Hawaii and the Pacific. The program applied for a new MCH distance education grant. If awarded all coursework will be offered online.

F. Health Systems Capacity Indicators

Introduction

The Health Systems Capacity Indicators (HSCI) measure the capacity of the system of care for the MCH population and the data capacity of the Title V agency to effectively monitor the health status of the MCH population. The data is reported on Forms 17-19. Data was collected for most of the HSCIs with the exception of the SCHIP and Medicaid linkage data that were not available (see narratives).

Resident data is used for reporting and planning purposes for the Title V measures unless noted and is determined by mother's resident area. Those reporting out-of-state addresses (e.g. foreign visitors or some military) are excluded from data reporting and generally amount to fewer than 0.5% of births.

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	27.0	24.4	20.5	18.6	22.9
Numerator	209	207	177	162	200
Denominator	77324	84879	86239	87207	87207
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009

Asthma defined by primary ICD9 codes 493.xx. Data were obtained from hospital discharge records acquired from the Hawaii Health Information Corporation (HHIC)-a private, non-profit corporation that maintains a database of health care encounters in the State. Data is for resident population and is by calendar year. Data for the year 2009 data is provisional. Population data based on U.S. Census Bureau, Population Estimates Program, “Annual Estimates of the Resident Population by Single-Year of Age and Sex for the United States and States: July 1, 2008.” (SC-EST2006-AGESEX_RES) (May 1, 2009). Estimates for the 2009 population were not available from the Census bureau at time of this report so the prior year estimate was used in the determination of the indicator.

Notes - 2007
Asthma defined by primary ICD9 codes 493.xx. Hawai‘i residents only. Population data based on U.S. Census Bureau, Population Estimates Program, "Annual Estimates of the Resident Population by Single-Year of Age and Sex for the United States and States: July 1, 2007" (SC-EST2007-AGESEX_RES) (May 1, 2008).

Narrative:
The 2009 provisional data indicate a rate of 22.9 children under 5 years of age per 10,000 were hospitalized for asthma. The Hawaii rate is lower than the Healthy People 2010 Objective goal of 25. Although the hospitalization rate for children < 5 years of age has remained relatively stable, the rate for emergency room visits by children with asthma is rising according to the Hawaii State Asthma Control Program (HSACP), the lead for asthma in the Department of Health (DOH).

To address asthma from a public health perspective, the HSACP focuses its efforts on three main content areas: (1) Surveillance; (2) Partnerships; and (3) Interventions. The following content areas continue to be driven by an explicit set of guiding principles outlined in the Hawaii Asthma Plan.

An example of interdepartmental partnerships is a recent collaboration between the HSACP, the Tobacco Prevention and Education Program (TPEP), and Title V's WIC services. In October 2009 a pilot project was initiated to learn how WIC clients in rural areas (low income women of child bearing age) are diagnosed and treated for asthma and tobacco use. The Lanai Community Health Center, a WIC contractor, is serving as the pilot site. A survey was created to capture information related to asthma and secondhand smoke. Interest in expanding the project to the community health center on the island Molokai is currently being explored.

In Hawaii, the highest proportion of hospital emergency department visits due to asthma is observed among infants, young children and women. Previous studies have suggested that asthma might contribute to low birth weight and increase the risk of pre-term deliveries. High asthma prevalence is also observed in child-bearing women and young children, especially those of low socioeconomic status and among Native Hawaiians.

HSACP is using Pregnancy Risk Assessment Monitoring System (PRAMS), administered by the Title V agency, to estimate the prevalence and burden of asthma among pregnant women. The HSCP epidemiologist is currently a member of the Hawaii PRAMS Steering Committee convened by the Title V Maternal and Child Health Branch.

In 2008 new volcanic activity from Hawaii island's Kilauea summit generated drastically higher levels of volcanic emissions or "vog". Before the new vent opened, the volcanic summit emitted 200 tons of sulfur dioxide per day, but now the crater releases about 2,000 tons per day. While most of the vog is blown out to sea with regular tradewinds, seasonal weather conditions have kept the vog lingering over Hawaii island for a number of days and created conditions serious enough to create potential health hazards for people with asthma and other respiratory conditions.

The DOH launched the "Hawaii Volcanos Helpline" in August 2008, a toll-free hotline that provides timely recorded public information on vog and emissions to the public and advice to minimize adverse effects. The information is updated daily.

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	87.1	87.4	85.3	89.7	89.1
Numerator	7141	6960	7292	7779	8147
Denominator	8201	7961	8552	8674	9144
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Data for this measure is from the Centers for Medicare and Medicaid Services (CMS) report form HCFA-416, Annual EPSDT Participation Report.

Notes - 2007
Data for this measure is from the Centers for Medicare and Medicaid Services (CMS) report form HCFA-416, Annual EPSDT Participation Report. Data for FY 2007 was not available for this report, but will be updated when it becomes available.

Narrative:
Data for this measure comes from the Med-QUEST Division (MQD), the Medicaid agency in the State Department of Human Services (DHS), HCFA-416 Annual EPSDT Participation report. The 2009 shows 89.1% of eligible infants received a service paid by the Medicaid program. Historically, Hawaii has had a high percentage of Medicaid enrollees under the age of one year receiving at least one initial EPSDT periodic screen.

Title V administers contracts to provide primary care services for the uninsured and perinatal support for women at high-risk for poor birth outcomes. Community health centers statewide that provide services to the uninsured are required to assist families with infants to apply for Med-QUEST insurance. The Perinatal Support Services contract also has a requirement to assist women in applying for insurance.

A federal grant administered by Title V, the Big Island Perinatal Health Disparities Program on the Island of Hawaii is designed to decrease infant mortality in high risk populations and does assure that each newborn has health insurance and well infant check ups with a health care provider.

Statewide WIC services also reinforce the importance of medical periodic screening for infants.

Initially when the infant is deemed eligible for services, the MQD program sends out information and the schedule of services to the parents. The EPSDT programs within the different health insurance providers have their own provisions to assure initiation of periodic screening. For example, in one program, the infant is scheduled for a two-week EPSDT exam before leaving the hospital (sooner if warranted) and mother is provided with a written schedule of expected well-baby visits. Mother also receives an appointment reminder telephone call the day before the

appointment. If she does not bring the infant in for the exam, the clinic tries to contact the family twice by phone and a certified letter.

Aloha Care, one of the MQD contractors, is working with Kokua Kalihi Valley Community Health Center to pilot an incentive program for parents of children 15 months and younger. Parents who participate in EPSDT screens are given a $10 Wal-Mart gift card. Parents who do not bring in their children who are younger than 15 months are contacted.

With the passage of the federal Children's Health Insurance Program Reauthorization Act of 2009 infants whose mothers are enrolled in Medicaid will now be automatically enrolled into Medicaid coverage, bypassing cumbersome documentation requirements. This policy change should help to expand coverage to infants and increase utilization of services.

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	87.8	87.8	87.8	87.8	87.8
Numerator	403	403	403	403	403
Denominator	459	459	459	459	459
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
Since SCHIP is a Medicaid expansion program in Hawaii, separate service utilization data is not available for SCHIP enrollees at this time. Thus data for this indicator are estimates. It is unclear whether the Medicaid agency will be able to provide this information in the future. Title V will continue to request this information.

Notes - 2008
SCHIP is a Medicaid expansion program in Hawai'i, separate service utilization data is not available for SCHIP enrollees at this time. Thus data for this indicator are estimates. It is questionable whether the Medicaid agency will be able to provide this information in the future. Title V will continue to request this information.

Notes - 2007
Since SCHIP is a Mediciad expansion program in Hawaii, separate service utilization data is not available for SCHIP enrollees at this time. Thus data for this indicator are estimates. It is unclear whether the Mediciad agancy will be able to provide this information in the future. Title V will continue to request this information.

Narrative:
SCHIP is a Medicaid expansion program in Hawaii. DHS implemented Hawaii's SCHIP program on July 1, 2000, by offering health insurance coverage to all children less than 19 years of age with family incomes up to 200 percent of the FPL. Under the 1115 waiver, the income eligibility

level was raised to 300 percent of the FPL in 2006. There is no waiting period for SCHIP eligibility. Enrollment in the Children's Health Insurance Program (CHIP) program has increased. Reauthorized by the Federal government in February 2009, CHIP provides incentives (i.e. greater flexibility to design CHIP programs and a higher Federal funding match) for states to extend public health insurance coverage to greater numbers of children from low-income families. Hawaii uses Tobacco Settlement revenues to fund the State match for CHIP and there is no asset test. No utilization data is available since Hawaii CHIP is a Medicaid expansion.

Refer to HSCI 2 and 7 for narrative on programmatic efforts to improve this indicator.

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	66.7	65.9	67.7	67.7	66.4
Numerator	11897	12436	12878	13105	12478
Denominator	17829	18873	19020	19348	18785
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Data is for resident population and is by calendar year. Data for the year 2008 was revised with an updated birth data file. Data for the year 2009 is based on a provisional birth data file.

Notes - 2007
Data is for resident population and is by calendar year. Data for the year 2006 was revised with an updated birth data file. Data for the year 2007 is based on a provisional birth data file.

Narrative:
The 2009 provisional data indicate 66.4% of women received an adequate number of prenatal care (PNC) visits. This shows the PNC adequacy rates have been relatively stable in the past 5 years. Multiple factors contribute to inadequate PNC visits including: a shortage of OB/GYN specialists in rural areas and neighbor islands; the rising cost of transportation; and the limited number of clients with Medicaid insurance that OB/GYN providers are willing to accept.

Title V funds staff to oversee the statewide Perinatal Support Services (PSS) contracts to promote early and continuous prenatal care. PSS provide enabling services such as transportation services and care coordination to ensure regular and adequate prenatal visits. The Healthy Mothers Healthy Babies Coalition of Hawaii implements and maintains a pregnancy resource and information toll-free phoneline and website to assist pregnant women and their families in finding a prenatal care provider and/or accessing Medicaid insurance.

The federal Healthy Start Perinatal Disparities grant on the Big Island of Hawaii will soon complete the first year of their second five year grant award. This project employs Neighborhood Women to do community outreach, language assistance, address cultural barriers, and provide

perinatal health education to Hawaiian, Pacific Islander, Filipino and Hispanic pregnant women with risk factors and all adolescents. Outreach workers provide transportation for PNC visits to encourage early and continuous PNC to those living in outlying areas of the Big Island.

Pregnant women from the Republic of Marshall Islands, Federated States of Micronesia, and Palau, who enter the state freely under a Compact of Free Association (COFA) agreement with the U.S., increasingly seek PNC in Hawaii. The State has consistently reported increasing costs for medical services provided to COFA migrants, which are only partially reimbursed by the federal government. COFA pregnant women often plan to deliver their infants in Hawaii, usually arriving late in their pregnancy. The community health centers see many of these women for PNC and assist them to enroll for Medicaid coverage.

The Kalihi-Palama Health Center (KPHC) has found success with the Centering Pregnancy group. Centering Pregnancy provides group PNC and health education for pregnant women with similar due dates and similar languages. The response from participants has been positive. The women look forward to their PNC visits and the ability to socialize with pregnant women of similar, or in some cases, differing ethnic backgrounds. But the women share similar pregnancy experiences and cultural/language barriers to care. The Kalihi-Kokua Valley (KKV) Comprehensive Family Services employs bilingual and bicultural outreach workers that are able to translate 17 Asian and Pacific Island languages for pregnant immigrant women to encourage early and continuous PNC to these population groups.

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	71.7	72.3	38.3	44.7	44.3
Numerator	90273	91323	56215	59194	64525
Denominator	125902	126344	146692	132459	145702
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009

Starting with 2007, the method used to calculate the data was changed, thus the lower rate is a reflection of the methodology change and not an actual decrease in service utilization. The new method is a more accurate rate of children receiving at least one screen. Data for this measure is from the Centers for Medicare and Medicaid Services (CMS) report form CMS-416, Annual EPSDT Participation Report. The numerator taken from Row 9: Total Eligibles Receiving at least one initial or periodic screen. The denominator taken from Row 1: Total individuals eligible for EPSDT. This indicator is reported on the 1 through 20 age group, and covers the federal fiscal year. Data includes SCHIP participants which is a Medicaid expansion program covering children up to 300% FPL in Hawaii.

Notes - 2007

Data for this measure is from the Centers for Medicare and Medicaid Services (CMS) report form HCFA-416, Annual EPSDT Participation Report. Data for FY 2007 was not available for this report, but will be updated when it becomes available.

Narrative:
The 2009 data shows 44.3% of eligible children received a service paid by the Medicaid program. The low percentage reflects the decline of service utilization rates for older children. A review of the data by age groups reveals that those children requiring increased screening are in fact utilizing services: Infants (89.1%), ages 1-2 years (78.1%), 3-5 years (60.0%), 6-9 years (31.5%), 10-14 (33.3%), 15-18 years (28.9%), 19-20 (10.5%).

The Title V agency's efforts to increase the percent of Medicaid-eligible children receiving a service paid by the Medicaid program are primarily enabling and infrastructure building services, conducted in partnership with other state and community agencies.

The Title V agency collaborates with the EPSDT program and the health plans contracted by Med-QUEST (MQD), the state Medicaid agency, to promote EPSDT. In addition, the Title V agency's purchase-of-service contracts to community-based providers require enabling services which promote appropriate utilization of all health services, including Medicaid services. These contracts promote a system of care for vulnerable populations, which includes translation and case management services.

MQD has updated the EPSDT examination form, which includes immunizations, screening, referrals, and care coordination needs. The standardized form gives providers clear guidelines about the required examination components, and provides information on screenings and immunizations by various ages. The Title V agency provided input to DHS on this form. MQD is assuring diverse community participation and expert advising regarding EPSDT through methods such topical meetings with specific stakeholders.

The MQD eliminated its EPSDT Coordinator position as part of the state reduction in workforce in October 2009. However, MQD continues to work with all health plans on two performance improvement projects: increasing access to care and reducing childhood obesity. To improve access to care, the Health Plan EPSDT Coordinators will continue to implement member outreach and provider training to support providers in meeting EPSDT goals. Outreach includes newsletters, and individual member reminder mailings. Delinquent letters are mailed when EPSDT visits are past due.

New software is being used to generate utilization reports for providers regarding preventive services. Health plans are exploring other methods to effectively target age groups such as an EPSDT health fair to improve utilization of preventive services.

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	54.0	53.3	47.7	56.4	53.9
Numerator	12998	12933	13633	14420	14851
Denominator	24060	24262	28557	25556	27552
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving					

average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Data for this measure is from the Centers for Medicare and Medicaid Services (CMS) report form CMS-416, Annual EPSDT Participation Report. The numerator taken from Row 12a: Total Eligibles Receiving Any Dental Services. The denominator taken from Row 1: Total individuals eligible for EPSDT. This indicator is reported on ages 6-9, and covers the federal fiscal year. Data includes SCHIP participants which is a Medicaid expansion program covering children up to 300% FPL in Hawaii.

Notes - 2007
Data for this measure is from the Centers for Medicare and Medicaid Services (CMS) report form HCFA-416, Annual EPSDT Participation Report. Data for FY 2007 was not available for this report, but will be updated when it becomes available.

Narrative:
The dental utilization rates for FY 2009 remained relatively stable from last year. Data for this measure comes from the Med-QUEST Division (MQD), the Medicaid agency in the State Department of Human Services (DHS), HCFA-416 Annual EPSDT Participation report. Statewide, the MQD provides dental services through a fee-for-service system that includes a strong case management component for families who have difficulty accessing dental services. The Community Case Management Corporation (CCMC) was hired by MQD to provide outreach across the state, community case management and coordinated state travel for neighbor island children who needed specialty care.

Over the years, MQD has updated the Neighbor Island fee schedule to increase reimbursement and decrease the paper work involved with the provision of care. In 2007 MQD hired Cyrca Dental as its new Third Party administer for the dental program. Cyrca provided outreach and training for providers. Dental providers were invited to join a list of dentists participating in Medicaid or CHIP on the national website "Insure Kids Now". Cyrca has been able to increase the number of neighbor island providers. Cyrca also established criteria and a fee schedule to repair cleft palate and an orthodontic fee schedule.

The neighbor island counties maintain active Oral Health Coalitions and also meet periodically in a Tri-County Dental Task Force. Accessing dental services is much more challenging on the rural neighbor islands since the highest concentration of dentists remain largely in urban Honolulu. CCMC and Cyrca participate in the county Oral Health Coalitions. The Primary Health Care Association sponsors a video conference/annual meeting of all the oral health coalitions statewide.

The Department of Health's Dental Health Division (DHD) was the state's lead agency in children's oral health data. In August 2009, the DHD, Dental Hygiene Branch was eliminated as part of the state Reduction in Workforce action. All DHD dental hygienists services were lost including statewide oral screenings at public elementary schools, administration of fluoride rinse programs, oral health education, and referral or follow-up in cases where serious oral health problems were identified.

Hawaii is now one of 27 states that have launched a Head Start Dental Home Initiative, developed in partnership between the Office of Head Start and the American Academy of Pediatric Dentistry, since 2008. The project goal is to ensure that all children enrolled in Head Start and Early Head Start (approximately 3,200 low-income children in Hawaii) have dental homes and access to comprehensive, continuous oral health care through a network of pediatric dentists and general dentists. Refer to narratives for NPM 9 (protective sealants) and SPM 05 (child dental caries) for other statewide activities.

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	24.6	26.1	34.4	26.4	42.8
Numerator	324	352	477	350	625
Denominator	1317	1350	1387	1325	1459
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
The numerator is from the Children with Special Health Needs Program. The denominator is from "Table – Number of children under age 16 receiving federally administered SSI payments, by state or other area, December 2009", Social Security Administration, Supplemental Security Record (Characteristic Extract Record format), 100% data. Table was sent to DOH CSHN Branch by the Healthy and Ready to Work National Center.

Notes - 2007
The numerator is from the Children with Special Health Needs Program. The denominator is from "Table - Number of children under age 16 receiving federally administered SSI payments, by state or other area, December 2007", Social Security Administration, Supplemental Security Record (Characteristic Extract Record format), 100% data. Table was sent to DOH CSHN Branch by the Healthy and Ready to Work National Center.

Narrative:
Data on children under age 16 receiving SSI payments was provided by the CSHNB/Children with Special Health Needs Program, in which social workers and other health professionals provide outreach services to medically eligible SSI applicants referred by Disability Determination Services, and to SSI beneficiaries referred by other community resources. December 2009 data on children under age 16 receiving SSI payments for Hawaii was provided by the Social Security Administration, in a table sent to CSHNB by the Healthy and Ready to Work National Center.

The data for 2009 shows 42.8% of SSI beneficiaries were served by the state CSHNB program, a substantial increase from 2008, however the rate has fluctuated over the past 5 years. The reasons for this are unclear.

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**

Percent of low birth weight (< 2,500 grams)	2009	other	8.3	7.9	8.1

Notes - 2011
Data were obtained from hospital discharge records acquired from the Hawaii Health Information Corporation (HHIC)—a private, non-profit corporation that maintains a database of health care encounters in the State. Hospital discharge data reflects the actual insurance or lack of insurance that was billed for the delivery. Cases of unknown or missing newborn insurance status at delivery were excluded from the "non-Medicaid" category but included in the "All" category. Infants with birth weights that were missing or <500 grams were excluded from all calculations. The data reflected in the chart is from births in calendar year 2009 and is limited to residents in Hawaii.

Narrative:
Medicaid linkage with vital statistics has not been achieved at this time, thus the data is not complete. Linkage efforts will continue through work funded by the MCH Bureau State Systems Development Initiative (SSDI) grant. Further, Hawaii vital statistics office has not adopted the 2003 revision of the birth certificate that some states are using to gather information related to Medicaid insurance.

Thus, the Title V agency purchased a license to access the relevant hospital/ER data using federal State System Development Initiative (SSDI) funds. The hospital data captures most births in the state including all Medicaid births. Medicaid requires all deliveries to occur in hospitals. There are only about 200 home births annually which are not in this dataset. Title V has met with HHIC to explore the possibility of linking hospital infant delivery records with birth and infant death certificates. HHIC had conducted a feasibility study for this linkage in 2005 when the linked dataset was generated for a research project related to the costs of premature births. However, issues regarding HIPPA restrictions, administrative concerns, and cost need to be addressed for sustaining on-going linkage. This linkage may be more feasible than the linkage between birth and Medicaid records.

The percentage of infants weighing less than 2,500 grams does not vary by Medicaid status in Hawaii (8.3% in 2009) compared to 7.9% among those not on Medicaid and 8.1% overall.

Please see narrative for HSCI #04 for program activities that influence the indicator. Early and regular prenatal care can help to reduce low birth weight and infant mortality rates.

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Infant deaths per 1,000 live births	2009	other	5.9	5	5.2

Notes - 2011
Data were obtained from hospital discharge records acquired from the Hawaii Health Information Corporation (HHIC)—a private, non-profit corporation that maintains a database of health care encounters in the State. Hospital discharge data reflects the actual insurance or lack of insurance that was billed for the delivery. Cases of unknown or missing child insurance status were excluded from the "non-Medicaid" category but included in the "All" category. Rates are three

year averages calculated by dividing the number of births by the total infant deaths during the period 2006-2008 according to child insurance (period rather than cohort method). The rate is limited to births to residents in Hawaii.

Narrative:
The rate of infant death is significantly higher among the Medicaid versus non-Medicaid population in Hawaii (5.9 versus 5.0 per 1,000). Future linkage of hospital discharge data to birth certificate data could help determine causes of excess death for the Medicaid population. Knowledge of the determinants of this disparity will help to direct programs to reduce infant death among the Medicaid-insured.

For plans regarding data linkage see narrative for HSCI 5A.

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2009	other	74.8	90.6	84.8

Notes - 2011
Estimates come from the 2008 Hawaii PRAMS survey and reflects those with a live birth in Hawaii without regard to residency status. The 2009 data reflects data collected among births that occurred during the 2008 calendar year. Insurance status was determined by a self-reported measure on the survey on how the delivery was paid for. Cases of unknown or missing insurance were excluded from the "non-Medicaid" category but included in the "All" category. In the future, hospital discharge data may be linked to the birth certificate so that figures will be based on the full population of women who deliver live births rather than a sample.

Narrative:
The rate for 2009 showed an increase receipt of prenatal care in the first trimester based on Hawaii PRAMS data for those on Medicaid, those not on, and for the overall total. Discussion is ongoing with HHIC and OHSM about linkage of data sets which may better clarify Medicaid status.

For plans regarding data linkage see narrative for HSCI 5A.

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05	**YEAR**	**DATA SOURCE**	**POPULATION**

Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State			**MEDICAID**	**NON-MEDICAID**	**ALL**
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2009	other	65.9	75.2	71.6

Notes - 2011
Estimates come from the 2008 Hawaii PRAMS and reflects those with a live birth in Hawaii without regard to residency status. The 2009 data reflects data collected from births that occurred during the 2008 calendar year. Insurance status was determined by a self-reported measure on the survey on how the delivery was paid for. Cases of unknown or missing insurance were excluded from the "non-Medicaid" category but included in the "All" category. In the future, hospital discharge data may be linked to the birth certificate so that figures will be based on the full population of women who deliver live births rather than a sample.

Narrative:
The rate for 2009 showed a small decrease in adequacy of prenatal care among women on Medicaid, but little change in the overall and those not on Medicaid. Discussion is ongoing with HHIC and OHSM about linkage of data sets which may better clarify Medicaid status.

For plans regarding data linkage see narrative for HSCI 5A.

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2009	185
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2009	300

Notes - 2011
Hawaii's SCHIP program is a Medicaid expansion with a ceiling of 300% Federal Poverty Level (FPL) for all age groups. The program covers children up to 18 years of age and does not include pregnant women over that age.

Notes - 2011
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Narrative:

In Hawai‘i, the Department of Human Services (DHS) is the Medicaid agency. Medicaid eligibility for infants is 185% of FPL.

Effective February 2009, the Child Health Insurance Program Reauthorization Act (CHIPRA) was signed by President Obama to renew and expand health insurance for children. "State" and "S" were dropped from the title, now called the Children's Health Insurance Program (CHIP).

Hawai‘i's CHIP is a Medicaid expansion program that extends health insurance for all children under 19 years old in families earning up to 300% FPL. There are no co-payments or premium payments required for QUEST and QExA (Hawai‘i's managed care Medicaid programs).

Regular QUEST and QExA are now 52% federal funds and 48% state funds. CHIP is 66% federal funds and 34% state funds. The application process is seamless for families as one application is used for these children's health insurance programs.

There is household income parity between the state-funded Immigrant Children's Plan and SCHIP. CHIPRA allows states to include immigrant and Compact of Free Association migrant children in its federally-funded programs. Therefore, Hawai‘i's Immigrant Children's Program is now federally funded since August 2009.

For updates on programmatic efforts to reduce the rate of uninsured children refer to the narrative for NPM 13 on children without health insurance. For updates on the QUEST Expanded Access program (QExA) for the Aged, Blind and Disabled (ABD population) see narrative in the Overview section.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children	2009	
(Age range 1 to 5)		133
(Age range 6 to 14)		100
(Age range 15 to 18)		100
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children	2009	
(Age range 1 to 5)		300
(Age range 6 to 14)		300
(Age range 15 to 18)		300

Narrative:
In Hawai‘i, the Department of Human Services (DHS) is the Medicaid agency. Medicaid eligibility for children 1-5 years is 133% FPL; while ages 6-18 are covered up to 100% FPL.

Effective February 2009, the Child Health Insurance Program Reauthorization Act (CHIPRA) was signed by President Obama to renew and expand health insurance for children. "State" and "S" were dropped from the title, now called the Children's Health Insurance Program (CHIP).

Hawai‘i's CHIP is a Medicaid expansion program that extends health insurance for all children under 19 years old in families earning up to 300% FPL. There are no co-payments or premium

payments required for QUEST and QExA (Hawai'i's managed care Medicaid programs).

Regular QUEST and QExA are now 52% federal funds and 48% state funds. CHIP is 66% federal funds and 34% state funds. The application process is seamless for families as one application is used for these children's health insurance programs.

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For updates on programmatic efforts to reduce the rate of uninsured children refer to the narrative for NPM 13 on children without health insurance. For updates on the QUEST Expanded Access program (QExA) for the Aged, Blind and Disabled (ABD population) see narrative in the Overview section.

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2009	185
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women	2009	200

Notes - 2011
Hawaii's SCHIP program is a Medicaid expansion with a ceiling of 300% Federal Poverty Level (FPL) for all age groups. The program covers children up to 18 years of age and does not include pregnant women over that age.

Narrative:
The Medicaid QUEST and state Child Health Insurance Program (S-CHIP) have special provisions that only apply to pregnant women. The provisions allow pregnant women to have enhanced access to prenatal care and other medical services. Special eligibility provisions for pregnant women apply throughout the term of pregnancy and continue through the 60-day period following childbirth. Pregnant women and children under age 19 are not subject to the asset test. Children under age 19 must not have countable family income that is more than 200% FPL. Pregnant adult women must not have countable family income that is more than 185% FPL. Pregnant women from Micronesia, the Marshall Islands and Palau who migrate to Hawai`i under the Compact of Free Association (COFA) with the U.S. government remain eligible for the same Medicaid coverage.

Coverage includes prenatal care, necessary tests, labor and delivery costs, hospital charges and doctor or certified nurse-midwife charges. Medical services for the newborn will also be covered.

Pregnant women under the age of 19 years that are ineligible for QUEST or S-CHIP can qualify for the QUEST-Net medical insurance up to 300% FPL. Individuals under age 19 with household income exceeding 250% of the FPL must pay part or all of a QUEST-Net monthly premium. Individuals under age 19 receive the same coverage as QUEST or the Medicaid FFS programs.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)	Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	1	No
Annual linkage of birth certificates and WIC eligibility files	3	Yes
Annual linkage of birth certificates and newborn screening files	3	Yes
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	3	Yes
Annual birth defects surveillance system	3	Yes
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2011

Narrative:
Since 2001, Title V has used the State Systems Development Initiative (SSDI) grant to facilitate data linkage with birth certificate files and improve access to key MCH surveys/registries. Annual data linkage for infant birth and infant death certificates occurs for infants at the DOH Office of Health Status Monitoring (OHSM), the vital statistics office. The Title V program has access to the linked database for analysis.

In 2004, the Children with Special Health Needs Branch (CSHNB) and OHSM began to link birth certificate files and newborn screening files for both newborn metabolic and hearing screening. Data linkage between birth certificates and WIC client files was achieved in 2007.

The only linkage that remains is between Medicaid and birth certificate datasets. Barriers to linkage include an out-of-state contractor that manages the Medicaid data system, data quality issues, funding/staffing shortage issues, new Medicaid priorities (transitioning the ABD population to managed care and responding to increasing Medicaid enrollments amidst state budget cuts). In

2008, Medicaid initiated an assessment of the current data system. It will likely be some time before data linkage can be seriously addressed. FHSD will await the findings of Medicaid's information system assessment but in the meantime sought to identify alternative data sources that could be used.

A linkage between hospital discharge data with birth certificates could yield similar data results to a linked Medicaid dataset for Title V Medicaid comparison indicators (HSCI 5). The hospital dataset captures most births in the state including all Medicaid births. The HHIC dataset also captures all of the infant deaths in the state. Using SSDI funds, a membership was purchased to access statewide hospital/ER data from the Hawaii Health Information Corporation (HHIC), the non-profit corporation that collects inpatient discharge records for Hawaii's 23 acute care hospitals.

In the area of registries and surveys, FHSD has achieved direct access to all the electronic databases: hospital discharge records, PRAMS, and birth defects surveillance. PRAMS data is accessible via the DOH data warehouse website which provides pre-designed tables/charts on many of the PRAMS survey questions.

FHSD is focusing on rebuilding the capacity to collect birth defects data since the Hawaii Birth Defect Program transitioned from a program contracted through the University to a DOH program with state-funded staff under FHSD's CSHNB. One position is now filled. The remaining 3 positions are vacant, but cannot be recruited due to a hiring freeze of state funded positions.

FHSD will work with HHIC to sustain direct access to hospital discharge records.

FHSD continues to expand its epidemiology capacity to conduct analysis and publish findings to ensure MCH data is using for planning and policy development. In the past 2 years, FHSD has published 3 major data publications and numerous facts sheets.

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	Yes

Notes - 2011

Narrative:
The purpose of this measure is to assure the state Title V agency's ability to access key MCH datasets for use in policy development and program planning. Since 1989, the Youth Risk Behavior Survey (YRBS) has been administered every two years in the Department of Education (DOE) in collaboration with the University of Hawaii. The University's Curriculum Research & Development Group (CRDG) has been contracted to administer the YRBS in Hawaii from 1993 to the present and is the repository for the electronic dataset. YRBS data has been placed into the DOH Hawaii Health Data Warehouse (HHDW) where the general public has direct access to preset standard reports and FHSD's advanced data users have direct access to the dataset.

In 2009, the FHSD Maternal and Child Health Branch Adolescent Health Program (AHP) worked with Don Hayes, FHSD's CDC-assigned epidemiologist and Jane Park, Research Associate from the Public Policy Analysis and Education Center for Middle Childhood and Adolescent Health (CMCAH) to conduct general YRBS data analysis and discuss publication formats for the YRBS data.

CMCAH analyzed Hawaii YRBS data and identified health issues with the most troubling trends and the most positive outcomes. The data analysis was used for the Title V needs assessment priority setting presentations and discussions. The most disturbing increases centered around violence-related issues and sexual behavior. Based on the findings, bullying prevention was selected as one of the state Title V MCH priority issues. Problem maps and fact sheets were developed to raise awareness, mobilize community partnerships, and develop collaborative strategies.

The CMCAH technical assistance was also used to discuss the development of a more general YRBS data publication to engage school educators, parents and youth to understand the importance of the survey.

The School Health Survey Committee (SHSC) which oversees the administration of all school health surveys in the state school system is also providing input on publication ideas and will assist with the development of an analysis plan. Membership on the SHSC includes the Department of Education, University School of Education researchers as well as the DOH School Health Coordinator and other DOH epidemiologists. Planning activities for YRBS 2011 include a data publication to accompany the YRBS consent forms sent to parents and a more comprehensive YRBS "Report Card" for parents, principals/teachers to use in the classrooms.

Rebecca Shor, is a Fellow at the Title V agency sponsored by the Council of State & Territorial Epidemiologists. She is conducting data analysis using PRAMS, YRBS, and BRFSS data on violence-related MCH issues. She was instrumental in resolving technical barriers to access the YRBS dataset directly and is conducting analysis using the dataset around issues of sexual violence among adolescents. She is working on a fact sheet, an abstract for the next MCH Epi conference, and manuscript.

IV. Priorities, Performance and Program Activities

A. Background and Overview

The Government Performance and Results Act (GPRA - Public Law 103-62) requires that each Federal agency establish performance measures that can be reported as part of the budgetary process that links funding decisions with performance and related outcome measures to see if there were improved outcomes for target populations.

In compliance with GPRA, the following progress report on the Title V Maternal and Child Health National and State Performance Measures is presented annually. The measures are reviewed by the Types of Service as shown in the pyramid in Figure 1. Specific program activities are described and categorized by the four service levels found in the MCH "pyramid" - direct health care, enabling, population-based, and infrastructure building services. Because of the flexibility inherent in the Block Grant, the program activities or the role that Title V plays in the implementation of each performance measure varies (i.e., monitor, advocate, provide, supplement, assure).

The goal for the state MCH agency is to focus on building the essential infrastructure services that assure an effective system of care exists to maintain the health of the MCH population.

Figure 2 presents schematically the Title V Block Grant Performance Measurement System designed to build state-level infrastructure capacity. The system begins with the assessment of needs, identification of priorities, program and resource allocation, tracking of performance measures, and culminates in improved outcomes for the Title V population.

The program activities, as measured by the National and State Performance measures, should positively impact the Outcome measures for the Title V population. While improvement in outcome measures is the long-term goal, more immediate success may be realized by a positive impact on the performance measures which are considered shorter term, intermediate, and precursors for the outcome measures. This is particularly important since there may be other significant factors outside of Title V programs that affect the outcome measures.

The performance measure system ensures fiscal accountability in three ways:

1) by measuring the progress towards successful achievement of the performance measures;

2) by having budgeted and expended dollars spread over all four of the recognized MCH services: direct health care, enabling services, population-based services, and infrastructure building services, and eventually;

3) by having a positive impact on the outcome measures.

Based on a five year needs assessment, the State Title V agency identified seven priority health issues of unique concern to the State. Form 14 lists the current state priority health issues. A state performance measure is identified for those priorities that are not already associated with a national performance measure. Form 16 includes detail sheets on each of the unique state performance measures. Like the national performance measures, narrative reports are also presented for the state measures. Title V staff members from every branch in the Division work with agency and community partners over several months each year to compile the extensive information and data required for the annual grant application and report.

Once submitted, the Block Grant application is subject to a standardized review process. The focus of the Review is on the progress being made by the State to meet its performance goals and to identify technical assistance that may be needed in order for the State to move towards

achieving these goals.

An attachment is included in this section.

B. State Priorities

Through surveys of key stakeholders and partners and other communications related to the 2010 Maternal and Child Health five-year needs assessment process, priorities were established that the community and the Title V agency jointly identified as important and that are within their capability to address. Many issues were raised during the needs assessment process that affect the health and well being of the maternal-child health population and are beyond the scope of Title V services particularly during these times of state budget deficits.

The Title V Needs Assessment Steering Committee identified seven priority. These priorities are the programmatic focus areas for FHSD work in partnership with other agencies/programs through 2015. Three priorities are continuing from the 2005 needs assessment: unintended pregnancy, child overweight (with a focus on early childhood), and alcohol use during pregnancy. Each priority is described in relationship to the National and State performance measures used to track them and are listed in no particular order.

Priority 1. REDUCE THE RATE OF UNINTENDED PREGNANCY
The performance measures related to this priority are:
NPM 8 the rate of births (per 1,000) for teenagers ages 15-17 years
SPM 1 The percent of pregnancies (live births, fetal deaths, abortions) that are unintended.

Priority 2. REDUCE THE RATE OF ALCOHOL USE DURING PREGNANCY
The performance measure related to this priority is:
SPM 2 Percent of women who report use of alcohol during pregnancy.

Priority 3. REDUCE THE RATE OF OVERWEIGHT AND OBESITY IN YOUNG CHILDREN AGES 0-5 YEARS
The performance measure related to this priority is:
NPM 14 Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.

Priority 4. IMPROVE THE PERCENTAGE OF CHILDREN SCREENED EARLY AND CONTINUOUSLY AGES 0-5 YEARS FOR
DEVELOPMENTAL DELAY
The performance measure related to this priority is:
SPM 3 The percentage of parents of children 5 months to 5 years who report completing a standardized developmental and behavioral screener (SDBS) during a health care visit in the past 12 months.

Priority 5. IMPROVE THE PERCENTAGE OF YOUTH WITH SPECIAL HEALTH CARE NEEDS AGES 14-21 YEARS WHO RECEIVE SERVICES NECESSARY TO MAKE TRANSITIONS TO ADULT HEALTH CARE
The performance measure related to this priority is:
NPM 6 The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work and independence.

Priority 6. REDUCE THE RATE OF CHILD ABUSE AND NEGLECT WITH SPECIAL ATTENTION ON AGES 0-5 YEARS
The performance measure related to this priority is:
SPM 4 The rate of confirmed child abuse/neglect reports per 1,000 for children ages 0-5 years.

Priority 7. PREVENT BULLYING BEHAVIOR AMONG CHILDREN WITH SPECIAL ATTENTION ON ADOLESCENTS AGES 11-18 YEARS
The performance measure related to this priority is:
SPM 5 Percent of teenagers in grades 6 to 8 attending public schools who report ever being bullied.

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	10	11	13	19	16
Denominator	10	11	13	19	16
Data Source				Hawaii NMSP	Hawaii NMSP
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	100	100	100	100	100

Notes - 2009
Data is from the State Newborn Metabolic Screening Program, Department of Health. The State of Hawaii tests for 32 disorders.

Notes - 2008
Since September 2003 Hawai'i tests for 32 disorders. The reported data maybe too small to calculate reliable measures. Unstable measures are not useful in making decisions. Caution should be exercised in the analysis of the reported data.

Notes - 2007
Data is from the State Newborn Metabolic Screening Program, Department of Health. Since September 2003 Hawai'i tests for 32 disorders.

a. Last Year's Accomplishments
The FY 2009 objective was met. One hundred per cent of infants who were screened positive received timely follow-up to definitive diagnosis and clinical management for conditions mandated by the State sponsored newborn screening program.

The Hawai'i Newborn Metabolic Screening Program (NBMSP) is administered by Children with Special Health Needs Branch (CSHNB). NBMSP has statewide responsibilities for assuring that all infants born in the state are tested for 32 disorders, meeting the national newborn screening recommendations from the American College of Medical Genetics and the March of Dimes for a

uniform panel of 29 disorders. The most recent disorder added to the screening panel was cystic fibrosis (CF). Hawaii's contracted newborn screening laboratory, the Oregon State Public Health Laboratory, started testing for CF in September 2007.

NBMSP continued to provide in-service sessions on CF and newborn screening in birthing facilities for physicians, nurses and laboratory staff; childbirth educators; public health nurses; midwives; and perinatal groups such as Healthy Mothers/Healthy Babies. NBMSP supplies informational flyers on CF and a newborn screening brochure for parents through health providers statewide.

NBMSP maintained oversight over the newborn metabolic screening system: obtaining blood specimens at hospitals, specimen transport, central laboratory testing, physician notification, and tracking. NBMSP staff tracked all infants who were diagnosed with metabolic and other disorders, had abnormal and unsatisfactory screening results, transferred to another facility, or were not screened. For infants who were confirmed with disorders, NBMSP identified the medical home, linked the medical home with the metabolic consultants, and followed-up with the medical home to ensure timely treatment. NBMSP established a nurse position to work with families and providers, to assist with coordination of services and follow up.

NBMSP funding is sustained through a $55 fee assessed for each screening specimen collection kit. The fees are deposited in a state newborn metabolic screening special fund.

Monthly newborn metabolic screening practice profiles were sent to birthing facilities and submitters, in an effort to decrease errors in transit time, timing of specimen collection, specimen quality, and reporting of demographic information. Birthing facilities use these screening practice profiles as a quality assurance tool. The screening profiles and updated information on newborn metabolic screening are also provided on the Department of Health website.

Because NBMSP can no longer obtain names of home birth parents identified through birth certificate data, there is great potential for missed and/or delayed diagnosed cases in the home birth population. Packets with newborn metabolic screening and newborn hearing screening information have been distributed to birth registrars to give to home birth parents when they register their infant for a birth certificate. To increase access to newborn screening for the home births, NBMSP has been giving newborn screening specimen collection kits to midwives and naturopaths without charge.

NBMSP continued involvement in the Genetics Program's Western States Genetic Services Collaborative, a federally funded multi-state project that seeks to coordinate and increase access to genetic services among the participating states and territory: Alaska, California, Guam, Hawaii, Idaho, Oregon and Washington. Project activities aim to improve the health of children with disorders detected by the newborn screening blood test, birth defects, and other genetic disorders through the use of telemedicine, improving genetic services data collection and use, newborn screening long-term follow-up data, and developing health outcome indicators for genetic services. The mission is to take a regional approach to coordination, sharing, and improving access to genetic services. Project funding is from the federal Maternal and Child Health (MCH) Bureau, Genetic Services Branch.

NBMSP has reported infant deaths due to fatty acid oxidation (FAO) disorders to the Child Death Review Coordinator. FAO disorders are known to cause 4-5% of the Sudden Unexplained Infant Death (SUID) cases, which might otherwise be labeled as SIDS. Newborn screening records are requested as part of the protocol in reviews of SUID cases.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service

	DHC	ES	PBS	IB
1. Contract for confirmatory alpha thalassemia testing.	X		X	X
2. Contract for centralized newborn laboratory testing.			X	X
3. Contract for transport of specimens to centralized newborn screening testing laboratory.			X	X
4. Support genetics clinics for children with metabolic and hemoglobinopathy disorders.	X	X		X
5. Follow-up/track infants to assure satisfactory newborn screening; track abnormal and unsatisfactory screening results; track infants transferred and/or not screened.	X	X	X	X
6. Follow-up with medical home and medical specialists to ensure timely follow-up to definitive diagnosis and clinical management for infants with newborn screening disorders mandated by the State sponsored newborn screening program.	X	X		X
7. Update/distribute newborn metabolic screening brochure to birthing facilities and providers.			X	X
8. Update/distribute newborn screening practitioner's manual (guidelines) to primary care providers.			X	X
9. Conduct educational sessions for practitioners, nurses, laboratories, and birthing facilities.			X	X
10. Quality assurance with monthly screening practice profiles and immediate feedback on unsatisfactory specimens sent to birthing facilities/submitters.			X	X

b. Current Activities

In 2010, NBMSP sent out a letter to all pathologists on the availability of newborn metabolic screening results to facilitate identification of infants with disorders. A copy of the newborn metabolic screening practitioner's manual was also enclosed.

The NBMSP Coordinator provided information at a Child Death Review Council meeting about newborn testing and infant autopsies.

NBMSP continues oversight of the newborn screening system, sends out monthly screening practice profiles to birthing facilities, gives newborn screening kits to midwives and naturopaths at no charge, funds the Hawaii Community Genetics program to provide follow-up services for metabolic disorders and the Hemoglobinopathy Clinic.

To improve Hemoglobinopathy Clinic services, NBMSP contracted for confirmatory DNA alpha thalassemia testing to improve genetic counseling services to families. This analysis is needed for accurate alpha gene mutation information.

CSHNB continues to contribute the services of genetic counselors, as well as services from the metabolic nutritionist and NBMSP coordinator.

NBMSP has been participating in a Genetics Program's multi-state Newborn Screening False Positives Project, funded by a MCH Bureau Discretionary Grant. Model educational materials and resources were developed for parents from diverse backgrounds to aid in the understanding of false positive results in newborn screening. Strategies to aid primary care providers in using the materials and resources were applied.

c. Plan for the Coming Year

NBMSP will continue to identify the medical home, link the medical home with the medical specialists, and follow-up with the medical home to ensure timely treatment for infants confirmed

with disorders. NBMSP will continue to work closely with the central laboratory and medical consultants to streamline procedures of notification and follow-up of test results.

NBMSP staff will continue to identify infants who did not receive newborn screening, based on "Specimen Not Obtained" forms and Hospital Monthly Newborn Screening Reports from birthing facilities, and will try to get these infants screened. NBMSP staff will also continue to provide education to health care providers, midwives, public health nurses, childbirth educators, and the general public about expanded newborn metabolic screening. NBMSP will utilize the Perinatal Advocacy Network, coordinated by Healthy Mothers/Healthy Babies Coalition, to disseminate information. More medical in-service sessions will be conducted to give feedback to the physicians regarding the findings of the expanded newborn screening program. Efforts will also be made to do more in-service education sessions with prenatal providers on expanded newborn screening testing, as mothers have clearly expressed the desire to learn about newborn metabolic screening from their prenatal care providers. NBMSP will also continue to provide more updated information on newborn metabolic screening on the websites.

NBMSP will continue to emphasize quality assurance by assisting each birthing facility to improve their newborn screening practice profiles through monthly reports and in-service sessions. NBMSP is also assisting each birthing facility to improve the quality of their newborn screening specimens by giving immediate feedback on possible reasons for the unsatisfactory specimens.

In addition, NBMSP will need to start exploring such issues as developing emergency preparedness plans; developing long-term follow-up data; improving insurance coverage for metabolic formulas and medical foods for diagnosed metabolic patients; developing policies and procedures for electronic transmission of laboratory and demographic data to birthing facilities and laboratories; and developing policies and procedures for retention and use of residual dried blood spots.

NBMSP will continue to participate in the Genetics Program's multi-state HRSA Western States Genetic Services Collaborative. The Genetics Program has applied for a two year CDC grant to develop and implement a collaborative pilot project with population-based surveillance of confirmed hemoglobinopathies of both pediatric and adult populations. Established sources of information, the newborn screening program and other data will be used. NBMSP will participate if Hawaii is awarded this grant.

In spite of state budget cuts, NBMSP will be able to carry out current and future activities because of sufficient funds in the NBMSP Special Fund.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	**19068**			
Reporting Year:	**2009**			
Type of Screening Tests:	**(A) Receiving at least one Screen (1)**	**(B) No. of Presumptive Positive Screens**	**(C) No. Confirmed Cases (2)**	**(D) Needing Treatment that Received Treatment**

					(3)	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	19005	99.7	8	0	0	
Congenital Hypothyroidism (Classical)	19005	99.7	115	9	9	100.0
Galactosemia (Classical)	19005	99.7	91	0	0	
Sickle Cell Disease	19005	99.7	2	2	2	100.0
Biotinidase Deficiency	19005	99.7	5	1	1	100.0
Congenital Adrenal Hyperplasia	19005	99.7	49	2	2	100.0
Cystic Fibrosis	19005	99.7	24	0	0	
Homocystinuria	19005	99.7	30	0	0	
Maple Syrup Urine Disease	19005	99.7	53	0	0	
SCAD	19005	99.7	1	0	0	
VLCAD	19005	99.7	8	1	1	100.0
Citrullinemia	19005	99.7	4	0	0	
Methylmalonic Acidemia	19005	99.7	5	0	0	
Multiple Carboxylase Deficiency	19005	99.7	5	0	0	
Arginase Deficiancy	19005	99.7	4	0	0	
Aginosuccinic Aciduria	19005	99.7	4	0	0	
Tyrosinemia, Type I, II	19005	99.7	2	0	0	
Carnitine Uptake/Carrier Defects	19005	99.7	3	0	0	
Carnitine/Acylcarnitine Carrier Defect	19005	99.7	4	0	0	
LCHAD	19005	99.7	2	0	0	
MAD/Glutaric Acidemia II	19005	99.7	5	0	0	
CPT I	19005	99.7	2	0	0	
CPT II	19005	99.7	2	0	0	
Glutaric Acidemia/GA I	19005	99.7	1	1	1	100.0
Isobutyryl CoA Dehydrogenase Deficiencey	19005	99.7	1	0	0	
Propionyl CoA Carboxylase Deficiency	19005	99.7	5	0	0	

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**

Annual Performance Objective	52.4	52.4	52.5	59.3	59.3
Annual Indicator	52.4	52.4	59.3	59.3	59.3
Numerator	10114	10114	20783	20783	20783
Denominator	19291	19291	35041	35041	35041
Data Source				National CSHN survey	National CSHN survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	59.3	59.3	59.3	59.3	59.3

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

a. Last Year's Accomplishments
Families of children with special health care needs (CSHCN) were involved in various ways, as council, task force, and advisory committee members; developing and reviewing parent education materials; in presentations and panels; interviewing applicants for staff positions; advocacy for legislation; and input on proposed changes for policies and procedures. Parents were compensated or assisted in various ways including stipends, airfare/ground transportation for Neighbor Island families, and child care during activities. Participants were of diverse ethnic and cultural backgrounds. Family members participate on the Hawaii Early Intervention Coordination Council, Newborn Metabolic Screening Advisory Committee, Early Hearing Detection and Intervention Advisory Committee, State Genetics Advisory Committee, and other committees.

Early Intervention Section (EIS) collected and used data from participating children and families for program improvement indicators/goals. Goals for families included understanding child's abilities and special needs, knowing rights and effectively communicating child's needs, helping their child learn/develop, adequate social support, and accessing services/activities. Goals for children included having social and emotional skills, learning and using knowledge and skills, and taking action to meet their needs.

The Newborn Hearing Screening Program (NBHS) worked to improve early hearing detection and intervention. Through the Baby HEARS-Hawaii Follow-up Project funded by the MCH Bureau, activities were planned toward goals to increase the proportion of families who receive family-to-family support at evaluation and intervention stages and conduct surveys about family satisfaction, service needs, and family support. "Sound Steps; Hawaii State Resource Guide for Families of Children with Hearing Loss," was developed and made available for families.

Children with Special Health Needs Program (CSHNP) developed with input from families, a Family Handbook and a Transition section of the Family Individual Plan. As part of the 2009 needs assessment, surveys were distributed to families of CSHCN statewide. Two state priority issues were selected based on the results.

The Hilopa'a Project (Integrated Systems for CSHCN), was a project of Children with Special

Health Needs Branch
(CSHNB) and Family Voices, with American Academy of Pediatrics-Hawaii Chapter and University of Hawaii (UH) Department of Pediatrics, with MCH Bureau funding. The Project increased family participation in program and policy activities. Guidelines on Compensation for Family Participation were implemented, shared/posted as a sample on CSHNB website. Parents of CSHCN were utilized as community facilitators for a Medicaid Infrastructure Grant, faculty for MCH Leadership in Education in Neurodevelopmental and Related Disabilities Program (MCH LEND), core committee to develop an EI parent-to-parent network, advisory committee for nurse practitioner fellowship program, Project Trainers, DOH/Developmental Disabilities Division Statewide Advisory, and State Council on Developmental Disabilities/Health and Early Childhood Committee. The Project Co-Director also served on the QUEST Advisory Council.

The Hilopa'a Family to Family Health Information Center (F2FHIC),project, funded by the MCH Bureau, was established by Family Voices of Hawaii in partnership with the Hawaii Pediatric Association Research and Education Foundation. "Veteran moms" provide family support and information which can be accessed by families on all islands by telephone and website.

Hawaii's Title V Family Trainers Academy trainees were parents, self-advocates, youth self-advocates, and community providers from all islands, some from rural areas. Training was supported and conducted by the Hawaii MCH LEND Program, Hilopa'a Project, and Hilopa'a F2FHIC. Graduates applied strengthened trainer/facilitator skills and knowledge about child health services in their community activities.

CSHNB facilitated the Autism Spectrum Disorders (ASD) Benefits and Coverage Task Force. The Governor appointed three parents of children with ASD as members of the Task Force. The group researched issues and made recommendations for health insurance coverage for ASD-related services and submitted a report to the 2009 State Legislature. CSHNB representatives attended an Act Early Summit for Region IX. Parents of children with ASD and an adult with ASD were Hawaii Team members.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Involve family members in councils, task forces, and advisory and planning committees; as interviewers for staff positions; in developing and reviewing parent education materials; as trainers or presenters; etc.				X
2. Promote and support the development of family leadership and family-professional partnerships.				X
3. Promote the inclusion of family participants in program and policy activities.				X
4. Promote the compensation of family members for participation in councils, task forces, etc.				X
5. Involve/support families in advocating for policy change, including legislation.				X
6. Disseminate Hawaii data on family partnership from the National Survey of CSHCN.				X
7. Use Hawaii data on family partnership in planning/improving outcomes for CSHCN.				X
8. Provide information/training to families, providers, and programs on resources and services for CSHCN and on navigating the system of services.		X		X
9. Assure the maintenance a Family to Family Health Information		X		X

Center.				
10.				

b. Current Activities
CSHNP instituted a Family Individual Plan (FIP) and Transition Checklist which is developed together with children and their families. Components of the FIP are reviewed annually with family input to assure the planning tool effectively addresses family concerns.

The NBHSP and Baby HEARS-Hawaii Follow Up Project facilitates several family support programs on Oahu for children who are deaf or hard of hearing. Parents in Paradise meetings are parent-led and provide parent-focused support. Ohana Time is a quarterly parent-to-parent support and information group. These community member parents help improve outreach and educational services to families.

The Hilopa'a F2FHIC continues to provide family to family support and information which can be accessed by families of CSHCN.

Hawaii's Title V Family Trainers Academy graduates continue to be utilized in community activities thus, strengthening their facilitation skills and knowledge about child health services.

"My Voice, My Choice" is a project of the State Council on Developmental Disabilities, Hawaii Disability Rights Center, UH Center on Disability Studies, and Self-Advocacy Advisory Council. A Youth Information, Training, and Resource Center helps to improve education and employment outcomes for youth by increasing their voice in the development of policies and services that affect their choices. The Youth Leadership Academy was held in April, 2010.

c. Plan for the Coming Year
Families will continue to be involved in various ways, including councils, task forces, and advisory committees; development and review of information materials for parents; participation in presentations and panels; participation in conferences and training sessions; interview panels for staff positions; advocacy for legislation; and providing input on proposed changes for policies and procedures. Parents also provide direct services to other parents through family support and education groups. Lastly, parents are routinely consulted for input to improve service delivery for CSHN programs.

Family Voices and the Hilopa'a F2FHIC will continue to provide trainings on Natural Supports, Transition, and the Rainbow Book, for families and professional partners. It will continue to provide family-to-family support and information which can be accessed by families of CSHCN via telephone, fax, written correspondence, email and the internet.

CSHNB will continue to monitor and disseminate data for this performance measure from the National Survey of CSHCN. Data on family partnerships was utilized to help identify state priority health issues for CSHN as part of the Title V needs assessment: improving screening for developmental delays and assuring transition planning services/resources to adult health care.

CSHNB formed workgroups for each issue to work on fact sheets, problem maps, identify key partners and resources to collaborate on identifying strategies to help families secure important services and information to address the health needs of their children. Both groups plan to collaborate on updates for the Rainbow Book (the guide to services for CSHN) and provide updated information for the F2FHIC.

The serious downturn in state and national economies and declining state revenues are resulting in large spending cutbacks in state government positions, and services. Spending reductions will reduce Children with Special Health Needs Program services and EIS services to children age 0-

3. Specific actions to address funding issues are being developed. State budget restrictions are expected to continue into 2011. CSHNB is monitoring the impact of these changes on CSHN and their families.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	47.9	47.9	47.9	45.2	45.2
Annual Indicator	47.9	47.9	45.2	45.2	45.2
Numerator	14657	14657	15632	15632	15632
Denominator	30627	30627	34568	34568	34568
Data Source				National CSHN survey	National CSHN survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	45.2	45.2	45.2	45.2	45.2

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

a. Last Year's Accomplishments
The medical home concept for all children, with and without special health care needs, has been promoted and supported by the American Academy of Pediatrics (AAP)-Hawaii Chapter, University of Hawaii (UH)/School of Medicine/Department of Pediatrics, DOH Family Health Services Division, and other public health programs.

The Hilopa'a Project (Integrated Systems for CSHCN) funded by MCH Bureau until April 2009, supported the Pediatric and Family Practice Residency Curriculum which extends teaching knowledge, skills, and attributes of the Medical Home to include integrated service system roles. Sessions included Medical Home Noon Conferences with facilitators and parent representatives, and orientation to the Rainbow Book with case studies on appropriate referrals to community services. The Hilopa'a Project was a collaborative effort of DOH CSHNB, Family Voices of Hawai'i, AAP-Hawai'i Chapter, and UH Department of Pediatrics.

Hilopa'a Project promoted an integrated developmental screening and referral process. The Project developed a referral flow chart with Parents' Evaluation of Developmental Status (PEDS) and Ages and Stages Questionnaire (ASQ) as standardized screening tools. The Project provided PEDS and ASQ training for pediatric providers, with assistance of the CSHNB

Preschool Developmental Screening Program.

Hilopa'a Project provided trainings on the "Rainbow Book--A Medical Home Guide to Resources for CSHCN and Their Families," which supports understanding and accessing community-based services. Trainees were professionals of various agencies, family members, and self advocates on all islands.

Children with Special Health Needs Program (CSHNP) supports medical homes by assisting families of CSHCN with access to services. CSHNP provides information and referral, outreach, care coordination, social work, and nutrition services for CSHCN age 0-21 years. Pediatric cardiology and/or neurology clinics are provided on the islands of Hawaii, Kauai, and Maui where services are not available. Financial assistance for medical specialty services is provided for eligible children who have no other resources.

CSHNP participates in the Kapiolani Medical Center Cleft and Craniofacial Center (KCCC) multidisciplinary team. The clinic provides coordinated, comprehensive services for children with craniofacial disorders with complex medical needs. CSHNP assists families as needed with access to KCCC services (including Neighbor Island travel), financial assistance for orthodontic services not covered by health insurance, and coordination of community-based services. CSHNP provides information about the clinic to public health nurses, physicians, dental specialists, speech pathologists, and other community providers.

The newborn screening programs include the medical home in their follow-up protocols. Early intervention services involve the medical home in the Individual Family Support Plan (IFSP) conferences, with family consent.

Department of Human Services contractors implemented a transition from Medicaid fee-for-service to QUEST Expanded Access (QExA) managed care for aged, blind, and disabled beneficiaries. Service coordination is a required component for the health plans. This increases service coordination and comprehensive care through primary care providers/medical homes.

The Autism Spectrum Disorders (ASD) Benefits and Coverage Task Force, established by the 2008 Legislature, completed and submitted its report to the State Legislature in December 2008. The Task Force purpose was to research the problems faced by parents of children with ASD and what can be done to ensure that proper benefits and services are provided through public and private resources to address the needs of children with autism. DOH CSHNB was the lead agency for facilitating the Task Force. The Task Force identified areas for improvement including: primary care providers (PCPs) may not be comfortable with the management of ASD or know community resources; PCPs may not have had training on the management of ASD and their role regarding care provided through public/private sector programs; and need for effective care coordination between medical, education and social services, primary and specialty care services, and state and community services.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Incorporate the medical home concept in direct/enabling services and in the planning/structure of CSHNB programs and services.	X	X	X	X
2. Disseminate Hawaii data on medical home from the National Survey of CSHCN and National Survey of Children's Health.				X
3. Use Hawaii data on medical home in developing and implementing plans to improve outcomes for CSHCN.				X
4. Promote developmental screening and follow-up. Inform				X

medical homes and other providers about the changes to the screening and follow-up system.				
5. Assist families of children in the Cleft & Craniofacial Clinic with coordinating services of community providers, promoting continuity of care and flow of communications, and providing information to community-based programs about the clinic.		X		
6. Continue collaboration and partnerships with other agencies and community-based organizations to promote/incorporate the medical home concept.				X
7.				
8.				
9.				
10.				

b. Current Activities
CSHNB programs continue to promote the medical home concept in various planning efforts and program services. These include CSHNP, newborn screening, early intervention, and genetics programs.

Various service coordinators continue to serve CSHCN and their families, in coordination with medical homes. These include Children with Special Health Needs Program service coordinators, Early Intervention care coordinators, Developmental Disabilities Division case managers, Public Health Nurses, and health plan service coordinators.

CSHNP provided input to two projects funded by Aloha United Way to screen preschool age children in two underserved communities. These projects will refer children to their medical homes for evaluation and care.

In working to improve services for children with ASD, CSHNB participates as a member of the Act Early Autism Hawaii Team and the Hawaii Center for Autism and Related Diagnoses (HICARD) Steering Committee.

As part of the Title V/CSHCN needs assessment, the identification of children with developmental delay was identified as a high priority. This relates to the medical home role in developmental screening and follow-up. A workgroup is gathering data, examining the nature of the problem, and identifying strategies and resources to address this issue.

CSHNB is monitoring the implementation of "patient-centered medical homes", which is beginning to be promoted by health plans in Hawaii as a way to improve patient care.

c. Plan for the Coming Year
CSHNB, Family Voices of Hawaii, AAP-Hawaii Chapter, UH Department of Pediatrics, and other organizations will continue to work toward accessible, family-centered, community-based, coordinated, comprehensive care through a medical home.

CSHNB programs will continue to promote the medical home concept in various planning efforts and program services.

CSHNP will continue to support the medical home by assisting families with access to services, through addressing financial access and assisting Neighbor Island children to obtain medical specialty services.

CSHNP will continue to work with UH Department of Pediatrics and Kapiolani Medical Center on the Cleft and Craniofacial Clinic.

Early Childhood Comprehensive Systems (ECCS) partners will continue work toward achieving the Hawaii ECCS State Plan's medical home outcome that all children will have access to and receive preventive and ongoing regular care. ECCS is under the DOH FHSD and the Strategic Management Team includes CSHNB representatives.

The Department of Human Services Med-QUEST Division updated the EPSDT examination form to include documentation of developmental and ASD screening using standardized tools and normal/abnormal result. The form provides clear guidelines about the required examination/screening components. When available, EPSDT screening data will be examined and used for further planning to promote developmental and ASD screening.

In support of the medical home role in screening, the Title V workgroup on the identification of children with developmental delay has proposed strategies that include: develop and disseminate products that promote optimal child development and provide information on developmental screening/follow-up services, advocate for funding to support screening/follow-up services for children with developmental delay, advocate for mandated insurance coverage for early intervention services, and promote public-private community-based partnerships for the screening system which includes guidelines/protocols, data, and training.

The DOH/CSHNB Preschool Developmental Screening Program (PDSP) closed in November 2009, due to reduction in force of all staff. Due to budget concerns, the DOH/CSHNB Early Intervention Section is proposing changes to the eligibility criteria for children age 0-3 years with developmental delay or diagnosed physical/mental condition with a high probability of resulting in a developmental delay. The loss of PDSP and proposed early intervention eligibility changes mean greater responsibility for follow-up by medical homes of children with developmental concerns. Information on eligibility changes and guidelines/resources for screening/follow-up will be provided to medical homes, other health providers, and community providers.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	70.2	70.2	70.2	73.5	73.5
Annual Indicator	70.2	70.2	73.5	73.5	73.5
Numerator	21980	21980	26078	26078	26078
Denominator	31318	31318	35459	35459	35459
Data Source				National CSHN survey	National CSHN survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**

Annual Performance Objective	73.5	73.5	73.5	73.5	73.5

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

a. Last Year's Accomplishments
Children with Special Health Needs Program (CSHNP) care coordinators/staff assisted children with special health care needs (CSHCN) and their families to obtain and maximize use of health coverage from public and other sources. As a safety net and to increase access to services, CSHNP provided medical specialty, laboratory, x-ray, hearing aids, cardiac and neurology clinics on Neighbor Islands, and air/ground transportation for eligible families with no other resources. CSHNP administers the Hawaii Lions Foundation Uninsured/Under-Insured Fund for hearing and vision services.

Newborn Metabolic and Newborn Hearing Screening Programs provided screening and diagnostic evaluations for families who could not afford the cost.

Until August 2009, the Preschool Development Screening Program provided developmental and behavioral screening for children and assisted with follow-up for concerns. Provided at no out-of-pocket cost to parents, services were closed by workforce/budget reduction of the entire program.

Early Intervention services for QUEST-eligible children are reimbursed under a Memorandum of Agreement (MOA) between the Department of Human Services (DHS) and the DOH.

Healthy Start home visiting services have been reduced from statewide services to serving 2 communities (on Hawaii and Oahu islands). An MOA between DOH and DHS ensures children under age 3 with substantiated child abuse and/or neglect will be provided developmental screenings through the Enhanced Healthy Start programs. Based on result of the screens, children are referred to H-KISS (central intake for EI services) and then forwarded to an EI program to determine if Part C eligible.

Part C, IDEA services include assistive technology; audiology; family training, counseling, and home visits; health services; nursing; nutrition, occupational therapy; physical therapy; psychological services; service coordination; social work; special instruction; speech-language pathology services; transportation; and vision services. Public Health Nursing Branch reduced its early intervention care coordination services for children age 0-3. EIS administers the DOH respite funding for children age 0-3 years with developmental delays and children/youth age 0-21 years with serious/chronic illness.

Hawaii Covering Kids collaborates with federal, state, and community agencies, conducts outreach, and helps Med-QUEST simplify processes to enroll and retain eligible children and youth in health insurance programs. DHS raised QUEST and Medicaid income eligibility levels up to 300% of the federal poverty level. Premium payments for children in households between 251-300% FPL (QUEST-Net) were eliminated.

DHS awarded the State contract for managed care plans to UnitedHealth Group (Evercare) and WellCare HealthPlans (Ohana) in February 2008. These QExA (Quest Expanded Access) plans cover eligible Aged, Blind, and Disabled (ABD) persons including children, in the Medically Fragile Community Care Program. The program provides a comprehensive package of medical, dental, long-term care, and behavioral health care. Services began in 2009.

The Hilopa‘a Project-Integrated Systems for CSHCN, funded by MCH Bureau, continued to conduct workshops to disseminate "The Rainbow Book--A Medical Home Guide to Resources for CSHCN and their Families," which includes practical information on Medicaid/QUEST,

Supplemental Security Income, and TriCare for military families. CSHNB continued updating content after April 2009 completion of the Project.

CSHNB facilitated the Autism Spectrum Disorders (ASD) Benefits and Coverage Task Force established by 2008 Legislation. It developed the 2009 Task Force report on problems faced by parents with recommendations to ensure proper benefits and services are provided through public and private avenues to address the needs of children with ASD. A July 2009 State Auditor report to the Legislature did not recommend enactment of the proposal for coverage of diagnosis and treatment of ASD for individuals under age 21. It noted both education and health interventions are available through federal/state programs under IDEA through the DOH and DOE. Cost to health insurers was an estimated $1 billion, likely passed on to the employer and consumer. However, the DOH position that private insurance treatments are needed to supplement existing services was acknowledged.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide information and assist uninsured CSHCN/families in obtaining health insurance.		X		X
2. Provide information/assist CSHCN/families in accessing other public resources, e.g., SSI, Medicaid waivers.		X		X
3. Provide or contract medical and other health services as a safety net for uninsured and underinsured CSHCN.	X	X		X
4. Identify and address issues and barriers that CSHCN/families have in accessing insurance/services to meet needs.				X
5. Support policy efforts to improve insurance coverage or services for unmet needs like Autism Spectrum Disorder.				X
6. Disseminate Hawaii data on health insurance from the National Survey of CSHCN and National Survey of Children's Health.				X
7. Use Hawaii data on health insurance to develop and/or implement plans to improve outcomes for CSHCN.				X
8. Provide training to programs, agencies, providers and families on navigating the service system and on best practices, protocols, and standards for referral and transition (including information on available health insurance resources)				X
9.				
10.				

b. Current Activities

CSHNB is updating "The Rainbow Book--A Medical Home Guide to Resources". It is featured by Hilopa'a F2FHIC website, which also provides ombudsman services for QExA clients.

CSHNB lost 53 positions abolished with the state reduction in force action in late 2009. This resulted in the closure of the Preschool Developmental Screening Program and two EI service locations: one on Oahu (Wahiawa) and another on Hawaii (Kona) island. Fiscal relief through the federal American Recovery and Reinvestment Act (ARRA) provided help to CSHNB/EIS for one year as the program works on changes to reduce costs. Services provided by state agencies/programs that assist families to secure and effectively utilize health insurance, including those in CSHNB, are further affected by mandated furloughs of state employees two days per month forcing the closure of many state offices and programs. CSHNP is reviewing the impact of workforce reductions and income guidelines held at 2008 levels for financial assistance.

CSHNB/EIS studied insurance coverage for EI services in other states, drafted a proposal to mandate coverage, and discussed it with the Hawaii Early Intervention Coordinating Council. The bill was not introduced due to the worsening state economy, rising mandated employer group health costs, likelihood of insurance companies passing additional coverage costs onto businesses and consumers, and other competing priorities. Legislation may be considered in future years.

c. Plan for the Coming Year

CSHNB programs will keep actively informed about national health care reform, local initiatives, and study how changes in policy and practices affect children, families, and communities. Direct and enabling services will continue as a safety net, as well as activities and communications to increase access to services for the uninsured and underinsured. Staff will continue to provide information and assist uninsured families in obtaining Medicaid/QUEST and/or other health care coverage.

Services and service planning with families will include Information and education about health plans, consumer utilization, self advocacy, and resources. Staff will continue to provide information and assist families in understanding economy of preventive practices and incentives in maintaining optimal conditions for overall health and functioning.

CSHNB will be involved in ASD-related matters concerning health insurance coverage and benefits, and service system improvements by providing resource consultation and follow-up from the 2009 Task Force legislative report.

Family Health Services Division, CSHNB, and EIS will continue to examine approaches to maintain early intervention services for families and identify alternative funding for services.

Together with CSHNB as part of the FHSD team, EIS and CSHNP will work with electronic information systems experts from the University of Hawaii - Manoa, Social Sciences Department to assist with the design of an electronic health record to be used initially in both programs to increase efficient processing and tracking of service applications, analysis, and reporting of information. The system should improve integration and sharing of data across programs; provide longitudinal availability of data for service coordination and efficiency; expand capability for reporting on client health status, services received, and health outcomes achieved; and expedite processing of reimbursements for services rendered.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	69.2	69.2	69.2	88.8	88.8
Annual Indicator	69.2	69.2	88.8	88.8	88.8
Numerator	13319	13319	31708	31708	31708
Denominator	19257	19257	35713	35713	35713
Data Source				National CSHN survey	National CSHN survey
Check this box if you cannot report the					

numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	88.8	88.8	88.8	88.8	88.8

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

a. Last Year's Accomplishments
Children with Special Health Needs Branch (CSHNB) programs work toward coordinated, family-centered services/systems:
- Early Intervention Section (EIS) is the lead for Part C of the Individuals with Disabilities Education Act (IDEA) for early intervention (EI) services for children age 0-3 years with or at risk for developmental delays. The EI service system includes a central directory, public awareness, child find, evaluation/assessment procedures, Individual Family Support Plan, personnel development, procedural safeguards, complaint resolution, financial policies, and data collection.-
Newborn Hearing Screening Program is responsible for the statewide system of newborn hearing screening, including diagnostic audiological evaluation and link to EI services, technical assistance, quality assurance, data/tracking, and education.
- Newborn Metabolic Screening Program is responsible for the statewide system of newborn metabolic screening,
including diagnosis and intervention/follow-up, data/tracking, quality assurance, and education.
- Children with Special Health Needs Program (CSHNP) provides medical specialty, nutrition, social work, pediatric cardiac and neurology clinics on Neighbor Islands, outreach for children with Supplemental Security Income (SSI), and other services as a safety net and to increase access to services. CSHNP now provides tele-nutrition services to Neighbor Island families.
- Genetics Program and state/community partners work to assure the availability and accessibility of quality genetic services in the state.
- Preschool Developmental Screening Program contributed to availability of developmental screening and follow-up services for children age 3-5 years, until the program discontinued services in August 2009 due to the state reduction in work force action.

The Hilopa'a Project-Integrated Systems for CSHCN funded by MCH Bureau concluded in April 2009. Many useful resources were developed for families with CSHN (including the "Rainbow Book --A Medical Home Guide to Resources for CSHCN and Their Families") and training conducted to assure effective utilization of the publications for state/community agencies, family members, and self advocates on all islands.

In 2009 as part of Title V Needs Assessment, CSHNB conducted a survey of over 500 providers, advocates, and families with CSHCN to identify priority health issues. Hawaii data from the National Survey of CSHCN was also considered. The priority areas identified were: 1) access to specialty services on neighbor islands, 2) screening of children age 0-5 years for developmental delay, and 3) transition of CSHCN to adult health care.

Hawaii Community Genetics, a partnership of CSHNB Genetics Program, Kapiolani Medical Center, Queen's Medical Center, and UH School of Medicine/Pediatrics, provides clinical genetic/metabolic services, with a full time geneticist, hemoglobinopathy clinic, neighbor island

clinics, and telemedicine visits. Western States Genetic Services Collaborative (WSGSC) expanded neighbor island clinics and telemedicine; and evaluated service delivery practice models. The Program's Sickle Cell Disease (SCD) Project developed a sickle cell protocol, education materials and training for primary care providers with families with SCD/Trait.

Neurotrauma Supports, DOH/Developmental Disabilities Division, addresses needs of injured persons and their families. Activities include maintaining a statewide telephone Helpline, assisting survivors and their families to identify and access services, providing education and public awareness, needs assessment, and Peer Mentoring project. CSHNB is a member of the State Traumatic Brain Injury Advisory Board.

Family Health Services Division (FHSD) coordinates the Fetal Alcohol Spectrum Disorder (FASD) Task Force for development of a comprehensive statewide system for prevention, identification, surveillance, and treatment of FASD. CSHNP is a member of the Task Force. Training was provided for FHSD staff, providers, and community programs.

CSHNP is participating in Kapiolani Medical Center's Cleft and Craniofacial Center. CSHNP provides service coordination, assistance with accessing specialized dental and orthodontic treatment services; transportation from neighbor islands; social services, etc. Without CSHNP services, many children with craniofacial conditions and their families are not able to use clinic and community based services easily.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide medical specialty and other services as a safety net for CSHCN who have no other resources, and to increase access to services.	X	X		X
2. Improve coordination of health, education, social, and other services for CSHCN.		X		X
3. Advocate/work toward addressing increased health service needs or gaps in available health care services				X
4. Provide education/training on services/resources for CSHCN.				X
5. Establish and maintain collaborative partnerships to address improving outcomes for CSHCN.				X
6. Disseminate Hawaii data on health and services system issues from the National Survey of CSHCN and National Survey of Children's Health.				X
7. Use Hawaii data and information on the current service system and resources identified through Title V needs assessment to develop collaborative strategies toward improving health outcomes for CSHCN.				X
8. Obtain information and provide training on community resources and navigating the system of services				X
9.				
10.				

b. Current Activities

CSHNB programs continue to increase access to specialty care and related services and support coordination of health, social, and other services.

Access to specialty care for neighbor islands was dropped as a state priority for the Title V needs assessment due to diminishing FHSD capacity resulting from the state budget cuts. Work groups

were formed for the remaining two issues (screening for developmental delays and transition to adult health care) to develop problem maps and fact sheets, identify resources and collaborative strategies to improve services.

CSHNB is updating information for the Rainbow Book, a popular resource for CSHN families to access services. It is featured on the Hilopa'a F2FHIC (Family to Family Health Information Center) website.

Genetics Program held a conference for public health and healthcare professionals in September 2009 on Personalized Medicine and Cancer Genetics. The Program hosted selected high school students and their teachers on Hawaii DNA Activity Day 2010, with forensic experts and hands-on activities. Activities to improve access to genetic services for neighbor island families are continuing with WSGSC evaluation projects and variety of approaches.

The FASD program networked school CSHN parent groups and offered FASD training to Department of Education staff.

CSHNB continued activities with the State Traumatic Brain Injury Advisory Board and assisting individuals with neurotrauma with accessing needed services.

c. Plan for the Coming Year

CSHNB programs will continue to provide services as a safety net for CSHCN and work toward addressing increased needs or gaps in available services, provide education/training, promote family consultation, and improve coordination of services for CSHCN. The issue of neighbor island access to pediatric specialty services will be explored working with neighbor island partners to explore new collaborative initiatives.

CSHNP will collaborate with community partners and families to improve consumer knowledge and utilization of available services and resources to meet family needs. The economic recession and budget cuts have brought major changes to the service system with reductions in both public and private funding. Health care reform will bring additional changes to health care delivery for CSHCN, families, and communities. Opportunities to increase system efficiency through improved information sharing and coordination of care will be explored.

Title V needs assessment workgroups on screening for developmental delays and transition planning to adult health care will continue to focus on updating information on existing services and resources, identifying key partnerships, and developing collaborative strategies to improve health outcomes.

Service planning, coordination, and follow up will be facilitated with development of an electronic record system in CSHNB, EIS and CSHNP. The programs are working with experts from the University of Hawaii to design an electronic health record that will be used initially in EIS and CSHNP. The project should facilitate more comprehensive service delivery.

Data from the National Survey of Children's Health and CSHN will be used to measure progress on the state priority issues. Further analysis of the data will be conducted, published, and shared for assessment and planning purposes.

With the FASD Task Force, FHSD will continue to facilitate the development of a statewide system for the prevention, identification, surveillance, and treatment of FASD. Activities include FASD awareness in general public and at-risk populations; advocating for, mobilizing, and coordinating state/community resources; and improving service delivery for individuals/families affected by FASD.

Neurotrauma Supports will continue to address the needs of people with neurotrauma injury and their families. The DOH will focus on assisting individuals with neurotrauma to access needed services through Medicaid. Staff will continue working on creating a neurotrauma registry and promoting education/awareness.

The Genetics Program with WSGSC will continue Practice Model analysis, and maximize efficacy of outreach and telemedicine services to distant areas. The collaborative will continue participation with medical home and MCH Leadership in Education in Neurodevelopmental and Related Disabilities Program (MCH LEND) representatives. Resources and activities needed to collect long-term follow-up data for newborn screening will be determined

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	5.1	5.1	5.1	39.4	39.4
Annual Indicator	5.1	5.1	39.4	39.4	39.4
Numerator	351	351	5024	5024	5024
Denominator	6937	6937	12766	12766	12766
Data Source				National CSHN survey	National CSHN survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	39.4	39.4	39.4	39.4	39.4

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

a. Last Year's Accomplishments
The foundation for transition begins in early childhood. The DOH CSHNB Early Intervention Section (EIS) provides planning and support for children with developmental delays exiting from early intervention (EI) services and transitioning to the Department of Education (DOE) preschool special education or other appropriate services. Transition activities include transition conferences to discuss services that the child may receive.

All DOE students as they enter into high school are required to begin developing a personal transition plan to support their moving from high school to post-secondary education and/or career.

DOE students age 16 years in special education must have a transition plan which includes needed services. Their Individualized Education Plan (IEP) must include transition statements that guide education and planning for high school and post secondary experiences. Transition teachers assist secondary special education teachers in preparing transition plans, through working with families to identify student interests/needs and coordinating transition services with community agencies.

A vocational rehabilitation model for culturally-diverse youth and young adults with disabilities was developed by the Successful Transitions in Diverse Environments (STRIDE) Mentoring Project. Transition to meaningful community environments, post-secondary education or employment was a goal. CSHNB was a member of the STRIDE Advisory Board during the project.

It Takes an ʻOhana (ITAO) (formerly Hawaii Foster Parent Association) issued a brochure "Resources Available for Foster Youth & Former Foster Youth", which can be used in "planning for future" conversations. Concurrent trainings were provided in October 2008 on supporting successful transition for resource (foster) parents, and preparing for future for youth ages 13-18. Act 183 (2008 Hawaiʻi State Legislature) included a guiding principle that foster children have life skills training and a transition plan starting at age 12, to provide adequate transition for children aging out of the foster care system. A series of 3 Better Start support/resource workshops, developed by collaborating community partners, were provided for youth ages 13-18 who were foster/adopted children or had guardians. Concurrent Resource Families Support Group sessions were presented by Family Programs Hawaii and Department of Human Services (DHS).

Hawaii Family Support 360 Project designed and implemented a Navigational One Stop System for youth age 14-21 years with a developmental disability transitioning to adulthood. Telephone assistance and Real Choices website were part of that information system.

A DOH Neurotrauma Help Line provides access to information and referrals to needed services, including QUEST Expanded Access. The website provides updated information and quarterly newsletters. A neurotrauma resource guide was provided to hospitals. CSHNB is a member of the State Traumatic Injury (TBI) Advisory Board.

"My Voice, My Choice" is a project of the State Council on Developmental Disabilities, Hawaii Disability Rights Center, University of Hawaii (UH) Center on Disability Studies, and Self-Advocacy Advisory Council. The project created a Youth Information, Training, and Resource Center to improve education and employment outcomes for youth by increasing their voice in the development of policies and services that affect their choices.

Children with Special Health Needs Program (CSHNP) social service and other health professionals continued to provide outreach services to medically eligible Supplemental Security Income (SSI) applicants less than 16 years of age referred by DHS Disability Determination Branch. Transition planning resources are provided in discussing plans with families.

The Hilopaʻa Project-Integrated Systems for CSHCN provided resource information, training, and education until it concluded in April 2009. The Rainbow Book included state/community resources for transition. A Transition Planning Workbook was a tool for families and service coordinators. Educational presentations were provided at family/professional conferences.

See also State Performance Measure #9.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**

1. Provide training/information on transition planning and support for children 0-3 exiting from Part C services to other settings including the preschool special education.		X		X
2. Provide transition planning and support as children/youth exit program services to other settings/services		X		X
3. Provide information and assist children/youth/families in accessing public resources, e.g. SSI or DD/MR waiver.		X		
4. Provide outreach to SSI/medically eligible children under 16 referred by Disability Determination Branch.		X		
5. Provide training/information on strategies for successful transition, including work, independence, and adult health care.				X
6. Participate and coordinate with other transition services/projects in community.				X
7. Disseminate Hawaii data on transition from the National Survey of CSHCN and National Survey of Children's Health.				X
8. Use Hawaii data on transition in planning/improving outcomes for CSHCN				X
9.				
10.				

b. Current Activities

As part of the Title V/CSHCN needs assessment, transition to adult health care was identified as a high priority. A Transition Workgroup, led by CSHNP, is gathering data, examining the nature of the problem, and identifying strategies and resources to address this issue.

CSHNP incorporates transition planning as part of the Family and Individual Plan for individual children/families.

Hawaii Emergency Transition One-Stop Summit generated recommendations for preparedness services to individuals with disabilities living independently. CSHNB is an Advisory Council member of this UH Center for Disability Studies project.

CSHNP attended the JAN (Job Accommodation Network, Office of Disability Employment Policy, Department of Labor) Inclusive Workplaces workshop on benefits of hiring and retaining employees with disabilities.

In February 2010, the Maui School District, with the Community Children's Council of Maui, held the second BIG MAC (Moving Across Community) transition fair for special education students and their families. The Family Voices State Coordinator presented on transition to adult life and introduced the Transition Workbook. Over 20 local and state agencies (including Family Health Services/CSHNP) hosted information booths.

DOH Neurotrauma is partnering with the UH Pacific Basin Rehabilitation Research and Training Center to implement a peer mentoring project to train mentors and have them assist persons with TBI to seek and use social services.

c. Plan for the Coming Year

EIS will continue to support the smooth transition of children exiting from early intervention services.

DOE Special Education will continue to address transition indicators in its Part B Six Year State Performance Plan (2005-2010). Indicators include % youth with IEPs graduating from public high schools with a regular diploma; % youth age 16 and above with an IEP that includes postsecondary goals, transition services, and annual IEP goals related to transition needs; and %

youth who had IEPs at the time they left secondary school and were enrolled in higher/postsecondary education and/or employed within 1 year after high school.

The State Council on Developmental Disabilities continues its effort toward a goal that family-centered, community-based, culturally-appropriate services and supports will be available to all children with special needs. Objectives include monitoring the transition between early intervention services and special education preschool and between preschool and kindergarten to ensure it will be a positive experience for children and families.

CSHNP guidelines will incorporate the Family and Individual Plan and transition planning (at least by age 14) as standard practice for every enrolled child/youth.

Changes with health care reform and effect on youth with special health care needs (YSHCN) will be monitored.

CSHNP social workers and other professional staff will continue to provide outreach to medically eligible SSI applicants referred by Disability Determination Services, and to SSI beneficiaries referred by other community resources.

Using Hawaii data from the National Survey of CSHCN, 2005-2006, CSHNB placed a fact sheet with outcomes, including those for transition, on the CSHNB website. As needed, CSHNB will continue to further analyze data for subgroups and comparisons.

The Title V workgroup on transition to adult health care has proposed strategies that include: develop, update, and disseminate informational resources and tools on transition planning; identify resources and current status of programs/services for transition planning; and increase collaboration and service integration to improve transition services for YSHCN and their families.

CSHNB will continue to monitor the availability of vocational rehabilitation services, related to the transition of youth from school to the workplace. Since October 2008, the DHS Division of Vocational Rehabilitation (DVR) has been in an Order of Selection due to the inability to provide services to all eligible individuals. Effective April 1, 2010, only Priority 1 (Most Significant Disability) category was opened. Clients in other categories continue to be placed onto a waitlist.

See also State Performance Measure #9.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	78.3	78.6	84.8	86.6	88.3
Annual Indicator	80.1	80.1	87.8	78.3	78.3
Numerator					
Denominator					
Data Source				National Immunization Survey	National Immunization Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events					

over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	90	91.7	92.4	92.4	92.4

Notes - 2009
Data on immunization series 4:3:1:3:3 comes from the U.S. National Immunization Survey (NIS), CDC. The survey reports the percentage of estimated state vaccination coverage, but does not provide the numerators and denominators used in the calculations. The estimate for the 2009 is not available at time of this report so the 2008 estimate was carried forward. The annual performance objectives have been modified to meet 90% by 2010. Subsequent objectives were set to increase at the same increment annually.

Notes - 2008
Data on immunization series 4:3:1:3:3 comes from the U.S. National Immunization Survey (NIS), CDC. The survey reports the percentage of estimated state vaccination coverage, but does not provide the numerators and denominators used in the calculations.

Notes - 2007
Data on immunization series 4:3:1:3:3 comes from the U.S. National Immunization Survey (NIS), CDC. The survey reports the percentage of estimated state vaccination coverage, but does not provide the numerators and denominators used in the calculations. The annual performance objectives have been modified to meet 90% by 2010. Subsequent objectives were set to increase at the same increment annually.

a. Last Year's Accomplishments
Provisional data from the National Immunization Survey indicate that 78.3% of children ages 19-35 months have completed the recommended schedule of immunizations in Hawaii in 2009. The annual state objective was not met. The State continues to lag behind the National Performance Measure goal of 90% by 2010. However, the State percent of 19 to 35 months olds receiving the full schedule of age appropriate (†4:3:1:3:3) immunizations was comparable to the national rate of 78.2%.

The Hawaii Immunization Coalition (HIC) a statewide community-based non-profit coalition of public and private organizations, advocates for on-time age appropriate immunizations of children before age two, with a focus on children vulnerable to vaccine preventable diseases. The HIC members address issues across the lifespan, with infant, adolescent and adult work teams to improve immunization rates for respective target populations. Advocacy, health education, direct services and raising awareness are activities by team members including a representative from the Maternal Child Health Branch (MCHB) and Women, Infant and Child (WIC) staff.

At the "2009 HIC Congress", priorities were identified to improve access and reduce barriers to immunizations using outreach and education. Actions proposed for the next 3-5 years include: having immunization information and forms in different languages; educating primary care physicians on the importance of not missing opportunities to vaccinate; developing a unified media campaign message; and, providing immunizations in communities using health vans (e.g. Mobile Blood Bank) during evening and weekend hours.

The Hawaii State Department of Health in partnership with the HIC took the lead for 2009 National Infant Immunization Week (NIIW) events. Community education on the importance of infant and early childhood immunizations was the focus for 2009 NIIW activities. The April 2009 YMCA Healthy Kid's Day Event reached approximately 3,000 individuals receiving immunization

information such as the coloring book Amy Immunosaurus, and two brochures What Every Family Should Know About Shots and Recommended Immunizations. During NIIW a short article on the importance of infant immunizations was distributed through the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Newsletters to Hawaii Medicaid (QUEST) members. An article on the recent increase in pertussis cases nationally and in Hawaii, and the importance of infant immunizations to statewide communities was in the Hawaii Medical State Association Newsletter distributed to 51,000 households and also through the Healthy Mothers, Healthy Babies Coalition of Hawaii listserv, reaching approximately 250 members. Throughout 2009 NIIW Medicaid plan providers distributed approximately 600 immunization schedules and information along with band-aid packs, coloring books and crayons.

The Public Health Nursing (PHN) Branch held immunization clinics for the uninsured and underinsured at statewide PHN sites. The immigrant population and the underinsured tend to utilize the PHN immunization clinics.

The Vaccine for Children (VFC) program provides immunizations to the uninsured, underinsured, American Indian, Alaskan Native and Medicaid children from birth to 18 years old through the federally qualified health centers, rural health clinics, Public Health Nursing (PHN) sites and participating primary health care providers statewide.

The initial pilot project of the Hawaii Immunization Registry (HIR) ended March 2009 with 240,000 immunizations entered from the seven participating pilot sites.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide immunizations for the under- and uninsured children at statewide clinics and community health centers.	X			
2. Provide referral and follow-up on immunizations for low income mothers through MCH programs.		X		
3. Provide education and outreach to at risk families of young children at community health centers.		X		
4. Provide education and outreach to promote immunization awareness.			X	
5. Support collaboration among agencies/programs to improve child immunization rates.				X
6. Develop policy to support increased immunizations among children.				X
7. Monitor immunization rates.				X
8. Develop a statewide immunization registry.				X
9.				
10.				

b. Current Activities

The Title V agency's Child and Youth Wellness section was eliminated due to the state Reduction in Workforce in October 2009. Staff in this section were responsible for child/infant immunization efforts. The agency is reassessing program priorities given remaining staff resources and reduced work hours due to mandated furlough days.

Primary Care and Healthy Start contracts and the WIC program require infant immunization education and referrals as part of its services. Healthy Start contracts continue to collect data on immunization rates and reported a 65% compliance rate for those receiving age appropriate immunizations by age two in 2009.

The State VFC program implemented by the Public Health Nursing Branch has Immunization Clinics for eligible individuals. These Immunization Clinics are held weekly in heavily populated immigrant areas like Kalihi and once a month in the more affluent area of East Honolulu.

In March 2010 the HIC held a general meeting with presentations on addressing budget cuts, legislative advocacy, and provided updated information on the pneumococcal virus and Haemophilus influenza type B vaccines for children. The Infant Team will continue to monitor the rate of appropriate immunizations by age 2 and develop public health messages to promote awareness and increase this rate.

The 2010 Legislative Session passed legislation to establish the HIR in State statute. The Governor signed the bill in May 2010 which goes into effect immediately.

c. Plan for the Coming Year

Plans for 2011 National Infant Immunization Week (NIIW) will include distributing information and toolkits to healthcare providers at grand rounds; expanding participation from community health centers and agencies; conducting public awareness efforts through community forums; and use of the Immunization Action Coalition website and e-cards developed by CDC.

The Infant Team of the Hawaii Immunization Coalition (HIC) is currently re-grouping in order to play a more active role to improve immunization rates for infants 19 to 35 month old. Title V staff will be assigned to the HIC Infant Team to assist in these efforts.

Hawaii Immunization Registry (HIR) is under the DOH Immunization Program. Currently, there are eight active providers inputting immunization records onto the registry with thirty interested providers on the waitlist. There is an enrollment process prior to enabling providers access and connection to the HIR to ensure confidentiality and security of the system. Providers and staff that will be inputting and accessing data from the HIR will receive training and sign confidentiality and security statements.

The Immunization Branch will focus on improving the capacity of the HIR to receive data from providers that use electronic medical records (EMR) and establish more provider connectivity to the HIR. HIR plans to request American Recovery and Reinvestment Act (ARRA) funds for this effort. Also HIR will work to encourage more neighbor island providers to use the HIR.

The Healthy Start program will continue to monitor participants for immunization status and tracking families as needed to improve immunization rates.

The West Honolulu Public Health Nursing office holds weekly immunization clinics and has observed that immigrant families tend to seek childhood immunizations only for school entry requirements. To encourage more timely immunization, the PHN office will routinely check whether infants and toddlers in immigrant families have up-to-date immunizations.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	22.5	22	18.6	18	17.5

Annual Indicator	19.4	21.6	19.8	18.7	18.1
Numerator	466	519	472	432	419
Denominator	24061	24065	23857	23097	23097
Data Source				Hawaii State Vital records	Hawaii State Vital records
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	17	16.5	16	15.5	15

Notes - 2009
Data is for resident population and is by calendar year. Data for the year 2008 was revised with an updated birth data file. Data for the year 2009 is based on a provisional birth data file. Population data based on U.S. Census Bureau, Population Estimates Program, "Annual Estimates of the Resident Population by Single-Year of Age and Sex for the United States and States: July 1, 2008" (SC-EST2007-AGESEX_RES) (May 1, 2009). Estimates for the 2009 population were not available from the Census bureau at time of this report so the prior year estimate was used in the determination of the indicator

Notes - 2007
Data is for resident population and is by calendar year. Data for the year 2006 was revised with an updated birth data file. Data for the year 2007 is based on a provisional birth data file. Population data based on U.S. Census Bureau, Population Estimates Program, "Annual Estimates of the Resident Population by Single-Year of Age and Sex for the United States and States: July 1, 2007" (SC-EST2007-AGESEX_RES) (May 1, 2008).

a. Last Year's Accomplishments
The 2009 data indicate a rate of 18.1 live births per 1,000 teenagers aged 15-17. The State objective of 17.5 per 1,000 was nearly met. Rates have remained relatively stable over the past 5 years. The comparable Healthy People 2010 objective for this Title V measure is to reduce pregnancies among females aged 15-17 years to no more than 46 per 1,000 females aged 15-17. Hawaii continues to meet the objective.

The 2007 Hawaii Youth Risk Behavior Survey (YRBS) results showed 36.2% of high school students reported having sex at least once; and 23.6% reported being currently sexually active. The rates are similar to those in 2005 and still remain lower than U.S. average.

The Abstinence-Only until Marriage Education (AOE) grant funding expired on June 30, 2009, which ended a thirteen year partnership with the Boys and Girls Club of Hawaii (BGCH). Hawaii was in year 1 of the new five year funding period (FY 2009 to 2013). The BGCH was able to conduct one cycle of the curriculum at two of their locations (Waianae and Spalding) before the AOE grant ended.

The Hawaii Catholic Charities (CC) was the sole state Community Based Abstinence Education grant recipient. CC's "Try Wait!" abstinence-only (AO) curriculum was provided in some of Hawaii's public schools, although this curriculum was not in compliance with the Board of Education's abstinence-based education policy, individual school teachers continued to request it

in classrooms. CC also provided AOE in private and charter schools on request. With a TANF grant from DHS, CC also provided case management and the abstinence-only curriculum to the National Guard Youth Challenge graduates. Funding also expired in June 2009.

Through Title X FPP contracts, Title V staff assisted in proposal reviews and provided input to identify critical geographic areas of need to help station FPP health educators to effectively provide outreach services to teens both in the classroom and in the community. Educators provide information on the benefits of abstinence, delaying sexual intercourse, contraception options, and importance of consistent condom use.

In 2008 the Legislature made a supplemental appropriation of $1.7 million to provide Family Planning Program (FPP) statewide contracted services including community based health education outreach services for teen pregnancy prevention. However, FY 2009 budget restrictions resulted in a cut of roughly $335,000.

State budget cuts were responsible for the elimination of the State's newly hired teen pregnancy prevention specialist. In the past, the Department of Health (DOH) and the Department of Human Services (DHS) executed a Memorandum of Agreement (MOA) to support teen pregnancy prevention activities using Temporary Aid to Needy Families (TANF) funding. TANF funds were used to support a position within the Title V Adolescent Wellness Program to coordinate the State's teen pregnancy prevention (TPP) efforts and to provide technical assistance (TA) and oversight for TANF funded programs conducted during non-school hours.

The Hawaii Youth Services Network (HYSN) continued to provide technical assistance and training to schools, community based organizations and health educators serving youth to use science-based approaches to prevent teen pregnancy. HYSN was 1 of 9 state organizations chosen to participate in the Centers for Disease Control and Prevention (CDC) Promoting Science-Based Approaches (PSBA) grant in 2005 which supports this work.

HYSN's statewide TPP leadership team, called the Healthy Youth Hawaii (HYH), provided guidance for continued capacity building activities and collaborated on statewide fairs and services in TPP. Title V and the FPP health educators are both members of this group.

The 2009 Legislature passed SB 777 which mandates all state-funded sex education programs provide medically accurate, factual, comprehensive, and age-appropriate information. DOH supports this measure through FPP, pregnancy counseling, sexually transmitted disease (STD)/HIV and sexual health education programs.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide teen pregnancy prevention education to students and communities.	X		X	X
2. Coordinate community planning efforts to prevent teen pregnancy.				X
3. Support inter-agency collaboration and networking to prevent teen pregnancy.				X
4. Provide technical assistance for contracted teen pregnancy prevention programs to promote evidence based interventions and program practice.				X
5. Contract for Abstinence-Only Education Program in selected at-risk communities.		X	X	X
6. Contract for family planning educational outreach and clinical	X	X	X	X

services.				
7. Support the administration of the Youth Behavioral Risk Survey in High Schools and Middle Schools to collect student health data for program planning.				X
8. Assure state-funded sex education programs are medically accurate, factual, comprehensive, and age-appropriate information				X
9.				
10.				

b. Current Activities

The State's economic downturn caused the elimination of positions and programs within DOH and DHS. Some of TANF's TPP contracts were not renewed. However, the Office of Youth Services (OYS) contracts remain intact for TPP programs and services this year.

Title V will continue to collaborate with HYSN's HYH to provide training opportunities to the non-profit agencies in positive youth development and teen pregnancy prevention programs by sharing reproductive health training resources from the State Adolescent Health Coordinator's positive youth development and TPP field experts.

Title V has secured epidemiological services to analyze the Youth Risk Behavioral Survey data for dissemination to school officials and staff, parents and the general public. Fact sheets on sexual behavior indicators will be included. For more information see the narrative for HSCI 9B.

Three federal stimulus and recovery TPP grant applications for comprehensive sex education have become available. Specifically, the teen pregnancy prevention program competitive grants are to address rising teen pregnancy rates by supporting both the replication of evidence-based models and demonstration programs to develop and test additional models and innovative strategies. Private non-profits like HYSN and Planned Parenthood submitted applications to replicate Making Proud Choices and Reducing the Risk.

c. Plan for the Coming Year

The 2008 provisional data has not yet been released. Objectives have been set to decrease by 0.5% annually.

The 2009 Hawaii Youth Risk Behavior Survey shows an increase from 2007 in public high school students reporting ever having sexual intercourse (44.3% vs. 36.2%), sexual intercourse prior to age 13 (6.0% vs. 5.1%), sexual intercourse with four or more persons during their life (11.1% vs. 6.1%). The 2009 data also indicated 47.7% of high school students who are sexually active did not use a condom during last sexual intercourse compared to 54.2% in 2007. There was also a decrease in the number of currently sexually active high school students reporting that they or their partner used a condom during last sexual intercourse (47.7% in 2009 compared to 54.2% in 2007).

The State Adolescent Health Coordinator will continue to work and collaborate with Title X FPP, HYSN, the DOE and other agencies in reproductive health and reproductive justice to reduce Hawaii's teen pregnancy rates and teen births.

There are 10 TANF-funded TPP service contracts still in place including the Youth Challenge case management and TPP program by the Catholic Charities. Funding will be available through February 2011.

Title V's MCH team applied for the TPP evidence-based replication grant through the newly created Office of Adolescent Health (OAH) within the Department of Health and Human Services

(DHHS). The Children's Aid Society's Carrera Program was the program selected from a list provided by OAH to be replicated in four areas with high teen birth rates: Ewa, Waianae/Nanakuli, Kauai and Molokai. This highly comprehensive TPP program is an out of school program, 3 hours a day, 5 days a week and all year round includes academic tutoring, family and life skills counseling, medical health services, creative arts, individual sports activities, a savings account and job preparation. Organizations will be required to track, monitor and maintain records on each youth in the intervention group as well as an experimental group over the course of five years. The target group will be youth 11, 12 and 13 years of age. Awards will be announced in September 2010.

Stakeholders participating in the Title V priority needs assessment did not identify teen pregnancy as a priority, however, did continue to recognize the need to reduce rates of unintended pregnancy.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	25	25	26	26	27
Annual Indicator	24.7	25.6	27.7	22.5	22.5
Numerator	782	886	824	554	554
Denominator	3171	3460	2971	2457	2457
Data Source				Hawaii DOH Dental Health Division	Hawaii DOH Dental Health Division
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	27	28	28	28	29

Notes - 2009
Data is from the Department of Health Dental Health Division (DHD) which conducts the child oral health surveillance program. Oral examinations are conducted by DHD dental hygienists in public elementary schools in accordance with accepted dental epidemiology standards. In November 2009 the DHD Dental Hygiene Brach was eliminated due to state budget cuts, thus ending school based oral health programs and child dental data collection. FY 2008 is the last complete year of data. The indicator for 2008 is used for 2009.

Notes - 2007
Data is from the Department of Health Dental Health Division (DHD) which conducts the child oral health surveillance program. Oral examinations are conducted by DHD dental hygienists in public elementary schools in accordance with accepted dental epidemiology standards. Objectives were revised based on FY 2004 indicator.

a. Last Year's Accomplishments
The Department of Health's (DOH) Dental Health Division (DHD) previously provided the data for this measure. The Division will no longer provide this data due to deep budget cuts and loss of staff.

Hawaii's children continue to have worst rates oral health in the nation despite relatively high dental insurance coverage partially due to the lack of public fluoridated water sources. Private and public stakeholders continue to work together to improve the oral health of children in Hawaii.

In 2009, the statewide Hawaiian Islands Oral Health Task Force (HIOHTF) continued to meet and worked closely with the Primary Care Providers in the community to build dental capacity in at-risk communities and promote the efforts of families to identify and utilize a dental home. Funding and dental insurance coverage remain a barrier and the Task Force (HIDHTF) will continue to work on building capacity in this area.

The Tri-County Oral Health Task Force, comprised of the neighbor island dental coalitions, meet quarterly while the Kauai Dental Health Task Force, the Hawaii Island Dental Task Force, and the Maui Oral Health Task Force continue to meet separately to address the needs of their communities. The groups ensure their efforts mirror the content areas and objectives found in the Task Force's plan. The neighbor island groups continue to be strong advocates for improving children's oral health.

WIC programs educate their clients on baby bottle tooth decay, early childhood caries prevention and the importance of the dental home and regular care.

Title V supports the availability of oral health services through its Primary Care Office activities in two ways: (1) completing the dental health shortage area designation, and loan repayment designations; (2) the provision of state dental health subsidy funds to many of the community health centers. The Community Health Centers which provide oral health services and who receive DOH subsidy are: Kalihi-Palama Clinic; Kokua Kalihi Valley, Waianae Community Health Center, Waimanalo Community Health Center for Oahu County; Bay Clinic and W. Hawaii Community Health Center for Hawaii County; Maui Community Health Center and Molokai Community Health Center for Maui County; and Kauai Community Health Center.

Dental care for children insured by Medicaid-QUEST is part of the Early Periodic Screening Diagnosis and Treatment (EPSDT) Program services for children 0-18 years of age. EPSDT services ensure that children from low-income families receive preventive health care such as well-baby and annual physical exams, immunizations and dental care. The EPSDT services recommend sealants for the first and second molars as preventive dental care. The low-cost health insurance plan for children through Hawaii Medical Services Association (HMSA) also covers sealants for the first and second molars every five years from 0-16 years of age.

Under legislation in 2007, the University of Illinois at Chicago Dental School was contracted by the DOH DHD to perform an assessment of the dental care services in the State. The report was released in 2009 with recommendations to improve the system of services for dental care in the State. Due to the significant economic downturn, there are limitations in the capacity of the public health and public assistance systems to address these recommendations at this time. The Maui Community College's accredited Dental Assistant training program continues to offer low cost dental services to the community at its training site.

Hui No Ke Ola Pono, Maui's Native Hawaiian Health System, employs a dentist that provides preventive education and dental assessments at various elementary schools on the island. The Department of Human Services' Head Start Collaborative shared the "Cavity Free Kids" curriculum from Washington State which has been used by Title V staff statewide.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide oral screenings, education and provide follow-up for serious cases in elementary schools.	X	X	X	X
2. Administer fluoride rinse programs in public schools.	X			
3. Collect, analyze and publish oral health data on children.				X
4. Provide funding for dental services to the under- and uninsured through community health centers.		X		
5. Provide oral health education to WIC low income pregnant women and young mothers.		X		
6. Implement provisions of the Oral Health Action Plan.				X
7. Support Neighbor Island oral health community coalitions to plan and conduct activities/programs.				X
8. Convene key stakeholders to identify and implement specific strategies to improve oral health for children.				X
9. Complete dental health shortage designations through the primary care office.			X	X
10. Administer state funded subsidies to cover oral health services for the uninsured through community health centers.			X	X

b. Current Activities

DHD no longer provides dental services and surveillance of school-age children statewide. The HIOHTF has identified the need for data surveillance as a continuing issue to address.
The dental services on the neighbor islands continue to grow. On Molokai, a Federally Qualified Health Center has been established and has a full time dentist and dental hygienist addressing the critical need for dental care for this rural community.

Three community health centers have expanded dental services with mobile dental vans acquired last year. Bay Clinic has four sites from Hilo to Kau; the West Hawaii Community Health Center services the Kona side of the island and also opened a pediatric dental clinic; and the newest mobile dental van serves the residents in Honokaa and Kohala.

Hawaii was one of 12 states to join the next phase of the national Head Start Dental Home Initiative developed in partnership with the American Academy of Pediatric Dentistry (AAPD). The project goal is to assure all children enrolled in Head Start and Early Head Start (roughly 3,000 low-income children in Hawaii) have dental homes and access to oral health care through a network of pedodontists and trained general dentists. The Hawaii Dental Association is identifying dentists statewide to participate in the program and help train those dentists who usually do not see young children. The Hawaii Head Start launched the project in May 2009 in conjunction with the annual meeting of the AAPD held in Honolulu.

c. Plan for the Coming Year

Title V will explore other options for tracking this measure in the future.

WIC programs will continue to provide oral health education for their clients.

Hawaii is now one of 27 states that have launched a Head Start Dental Home Initiative developed in partnership between the Office of Head Start and the American Academy of Pediatric Dentistry, since 2008. The project goal is to ensure that all children enrolled in Head Start and Early Head Start (approximately 3,200 low-income children in Hawaii) have dental homes and access to comprehensive, continuous oral health care through a network of pediatric dentists and general

dentists.

The Hawaii Head Start initiative was launched in May 2009, in conjunction with the annual meeting of the APPD held in Honolulu. Since that time, the following activities have been conducted: informational meetings have been held with dental hygienists and dentists on Hawaii Island, and with dental directors of Community Health Centers; a DVD that focuses on promoting parent awareness about the importance of starting oral health practices early has been produced and will soon be replicated and available for distribution to Head Start/Early Head Start programs to use in parent workshops; plans are being developed to partner Lutheran Pediatric Dental Residents with HS/EHS programs around dental screenings and oral health education activities; and a grant from the Hawaii Dental Services Foundation has been secured to purchase copies of Brush'um and dental starter packs for all HS/EHS enrolled children, statewide. State team meetings are convened quarterly, and Head Start staff attend Neighbor Island Oral Health Task Force meetings to share information and participate in other oral-health related activities.

Title V also recognizes the serious oral health care challenge for Hawaii's children. Plans are to build on existing infrastructure services by focusing on the utilization of the existing oral health resources, with emphasis on the dental home. Title V staff will continue to collaborate with DHD, the dental providers, pediatricians, and community programs serving families to ensure that each child has an appropriate dental home and is accessing routine care, particularly, children with special needs.

The proper use, placement and monitoring of dental sealants is one important aspect of this preventive, routine dental care. Most dental insurance plans in Hawaii cover sealant placement and the number of children with insurance is relatively high, although this may decline with the state's economic downturn and increased layoffs.

Title V will support the recommendations of the HIOHTF and participate in activities where possible. In addition, FHSD will continue to process the oral health underserved federal designations and continue its state funded grant subsidies to the various community health centers in all four counties.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	3	2	1.4	2	2
Annual Indicator	2.0	2.7	2.5	2.5	2.2
Numerator	14	19	18	18	16
Denominator	706304	715232	712175	712175	712175
Data Source				Hawaii State Vital records	Hawaii State Vital records
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.			Yes	Yes	
Is the Data Provisional or Final?				Provisional	Provisional

	2010	2011	2012	2013	2014
Annual Performance Objective	2	2	2	2	2

Notes - 2009
Due to the small number of motor vehicle deaths, a three-year annual average is being reported. The reported data maybe too small to calculate reliable measures. Unstable measures are not useful in making decisions. Caution should be exercised in the analysis of the reported data. Data is for resident population and is by calendar year. Data for the year 2008 was revised with an updated death data file. Data for the year 2009 is provisional. Population data based on U.S. Census Bureau, Population Estimates Program, "Annual Estimates of the Resident Population by Single-Year of Age and Sex for the United States and States: July 1, 2008" (SC-EST2007-AGESEX_RES) (May 1, 2009). Estimates for the 2009 population were not available from the Census bureau at time of this report so the prior year estimate was used in the determination of the indicator.

Notes - 2007
Data is for resident population and is by calendar year. Data for the year 2006 was revised with an updated death data file. Data for the year 2007 is provisional. Population data based on U.S. Census Bureau, Population Estimates Program, "Annual Estimates of the Resident Population by Single-Year of Age and Sex for the United States and States: July 1, 2007" (SC-EST2007-AGESEX_RES) (May 1, 2008). Due to the small number of motor vehicle deaths, a three-year annual average is being reported.

The reported data maybe too small to calculate reliable measures. Unstable measures are not useful in making decisions. Caution should be exercised in the analysis of the reported data.

a. Last Year's Accomplishments
Three-year averages were used to calculate the indicator for this measure because the numbers are small and vary substantially from year to year. The provisional data for the 2009 indicator is 2.2. The State objective was nearly met. The rates have stayed relatively stable over the past 5 years.

In 2009 substantial roadway safety legislation was successfully adopted into law designed to improve safety and prevent of motor vehicle deaths. Bills include Act 54 Complete Streets Law, Ignition Interlock law, Graduated Driver's Licensing, Safe Routes to School Act and Section 15-24.23 of the Revised Ordinances of Honolulu and Hawaii County Ordinance 0982A concerning cell phone ban prohibits the use of mobile electronic devices while operating a motor vehicles. Many of these bills were identified as strategic objectives in the Hawaii Department of Transportation Strategic Highway Safety Plan: 2007-2012.

Act 54, the Complete Streets law requires the state Department of Transportation (DOT) and all counties to establish policies to accommodate all users of the road, no matter the age, ability or mode of transportation. A task force will report to the 2011 Legislature on design standards and procedures to assure that safe and convenient walking and biking facilities are incorporated in all transportation projects.

The Hawaii Ignition Interlock Task Force made recommendations to amend the Hawaii Ignition Interlock law passed the previous year, to assure rules and procedures were in place to facilitate implementation. The law will help reduce alcohol related crashes which are consistently high in Hawaii. Costs for installation and monthly maintenance of the ignition interlock device required for all offenders, not just repeat offenders will be provided by a fee paid for by offenders rather than tax payers. The average cost per person is estimated at $800.

Act 85 amended the existing Hawaii law for Graduated Driver's Licensing to remove the sunset provision to make the law permanent.

Safe Routes to School, Act 100 requires the DOT to conduct a statewide survey to understand how students get to school and produce an annual report. Survey findings will be used for school-based workshops and community plans to reduce traffic congestion, encourage walking and bicycling to schools. DOT continues support of a statewide advisory committee to improve child car safety.

The Keiki (Child) Injury Prevention Coalition (KIPC) secures resources for trainings and meetings that provide a forum for sharing initiatives to inform the public about laws to protect children from motor vehicle dangers; graduated licensing, the primary seatbelt law, child restraint law, booster seat law, unattended child passenger law, moped pedestrian law, bicycle law, motorcycle law, child riding in pick up trucks law, and moped law.

Car seat education was publicized extensively in the news during September 2009 National Child Passenger Safety Week. A press conference and proclamation signing coordinated by KIPC involved all the county police captains, the DOT Director, Lt. Governor and state car seat instructors. Roadblocks raised visibility and effectiveness of car seat usage during this week. Oahu police yielded almost 400 citations of which 61 were specifically for lack of car seats. Retail vendor training needs were identified and will be addressed.

The lead child passenger safety trainer for Hawaii attended the annual "Lifesavers 2009 Conference" and has shared best practice updates. New car seat technicians (25) were trained and others (13) received refresher training provided by the KIPC car seat program. A special grant was awarded to Kauai to attend due to lower rates of booster seat compliance. Car Seat Technician training was held at the Kaneohe Marine Corps base. Participants were from hospitals, Sheriff's Department, Police Departments and vendors. Mandated child safety classes handled by The Judiciary in Honolulu required for persons who receive traffic citations, need a certified child passenger instructor. A Castle Medical Center car seat station is in development.

The annual "Click It or Ticket" education and enforcement program tracks child passenger seat usage on all islands. The Child Death Review System continues to update participants on policies to protect all children during case discussions at child death reviews. Risk factors and demographics are collected for CDR reports.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Collect data/information on child injury and death to use for policy development and planning.				X
2. Conduct educational outreach on child passenger seats, bicycle and pedestrian safety.			X	X
3. Enforce seat belt and child safety laws through “Click It or Ticket” program and training police department staff.				X
4. Conduct safety seat checks through an extensive network of permanent sites and at special events.		X	X	X
5. Conduct training for safety seat inspection/installation technicians and instructors.			X	X
6. Conduct safety seat inspection and loaner program for children with special needs.		X		
7. Identify prevention strategies by reviewing information surrounding child deaths.				X
8. Support state and community injury prevention coalitions.				X
9.				
10.				

b. Current Activities
Participation in KIPC allows for increased knowledge about child safety. New Title V staff participate in KIPC due to a Reduction in Force which eliminated the Child and Youth Wellness Section. Title V staff report on preventive activities conducted by service contractors and findings from the Child Death Review.

Safe Kids International Walk to School day was held on October 1st at Kalihi Waena Elementary School in partnership with FedEx and volunteers from the Coast Guard and AMR Emergency Services. KIPC also received an award from SafeKids Worldwide for a $3,000 grant to develop a Hawaii school safety committee to continue pedestrian safety.

The Department of Transportation (DOT) has been unable to fill the two vacancies in the Highway Safety Section. DOT awarded KIPC $96,000 for the Car seat Program. This is the first funding increase in several years. Continued training of car seat technicians is needed an ongoing. In October 2009, the DOT held a statewide child passenger safety technician training. Approximately 75 certified technicians attended the two day refresher course to ensure that Hawaii's technicians have the most current information available. A second training is being planned in September 2010 for child passenger safety instructors.

KIPC provided testimony to support legislative measures to increase penalties on drivers with repeat excessive speed violations; ban all hand held technology while driving, and the ignition interlock task force recommendations.

c. Plan for the Coming Year
The Queens Medical Center Injury Prevention and Research is conducting research on "Effects of Booster Seat Law on Pediatric Motor Vehicle Injuries" to determine if the law made a difference. MCHB staff was reduced due to retirement and RIF, six Child Death Review teams continue reviews for a report.

The DOT is also planning a media campaign to support the national Child Passenger Safety Week in September. As part of the campaign, all four county police departments will be enforcing the child passenger laws at public schools to ensure compliance with Hawaii's laws.

The DOT's Walk Wise Hawaii campaign will be partnering with one of Hawaii's largest preschools to promote pedestrian safety.

Traffic Safety recommendations will be updated as one content area of the revised Hawaii Injury Prevention Plan (HIPP).

The Child Death Review Program will release a report on deaths that occurred during 2001-2006. This report will also include recommendations for policies and actions to promote the prevention of motor vehicle events.

Legislation is needed to require children to wear helmets when using mopeds, motorcycles and all terrain vehicles. Legislation to require moped and motorcycle passengers and operators to use helmets (HB 2898) was introduced in the 2010 Legislative session and deferred. Child safety advocates will continue to support reintroduction of this bill as well as legislation for all terrain vehicles.

The DOT will continue to support the national Click It or Ticket and Child Passenger Safety week campaigns.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		46	47	48	55
Annual Indicator	49.3	55.4	55.2	56.7	56.2
Numerator				186	140
Denominator				328	249
Data Source				Hawaii WIC	Hawaii WIC
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	56	57	58	59	54

Notes - 2009
The data for this measure is from the 2009 National Immunization Survey (NIS), Centers for Disease Control (CDC) Department of Health and Human Services. Data is reported by the year of the child's birth to make it easier to evaluate breastfeeding interventions and progress toward the Healthy People 2010 breastfeeding objectives. The latest data is from birth year 2006. This data is used to report for FY 2009. Data for the 2006 cohort is provisional, to be updated in 2011. Data for the 2005 cohort is updated.

Notes - 2008
The data for this measure is from the National Immunization Survey (NIS) http://www.cdc.gov/breastfeeding/data/nis_data/data_2004.htm by the Centers for Disease Control (CDC). This year, the NIS changed how breastfeeding data was reported. In the past, the NIS presented breastfeeding information by year of respondent interview; however, now breastfeeding information is presented according to the year of the child's birth. This change is intended to make it easier to evaluate breastfeeding interventions and progress toward the Healthy People 2010 breastfeeding objectives.

Notes - 2007
The data for this measure is from the National Immunization Survey (NIS) http://www.cdc.gov/breastfeeding/data/nis_data/data_2004.htm by the Centers for Disease Control (CDC). This year, the NIS changed how breastfeeding data was reported. In the past, the NIS presented breastfeeding information by year of respondent interview; however, now breastfeeding information is presented according to the year of the child's birth. This change is intended to make it easier to evaluate breastfeeding interventions and progress toward the Healthy People 2010 breastfeeding objectives. The latest data is from birth year 2004, but reflects data collected during 2004-2005. This data is used to report for FY 2006 and 2007. The FY 2005 indicator reflects NIS data utilizing the old NIS reporting method, so is not comparable to FY 2006 data. The data for birth year 2005 is expected to be released by August 2008.

a. Last Year's Accomplishments
The provisional FY 2009 data indicates that in 2006, 56.3% of Hawai'i mothers were breastfeeding their infants at 6 months, a slight decrease from the previous year (56.7%). Hawaii

has seen a large overall increase from birth year 2000 (34.1%), the first birth cohort surveyed by NIS. The 2009 indicator met the objective of at least 49% of women breastfeeding their infants at 6 months of age. Hawaii also surpassed the national rate of 43.4% and exceeded the Healthy People 2010 objective of 50%.

The Title V program promotes breastfeeding by providing enabling, population based, and infrastructure building services. Title V perinatal support services contractors provide comprehensive breastfeeding education and support to clients. Other community-based programs that promote breastfeeding include: the federal Healthy Start Project on the island of Hawaii; Early Head Start, and programs under the Native Hawaiian Health Systems.

WIC provides breastfeeding promotion, education and support to their pregnant and postpartum clients. Services include an incentive program, a breast pump loan program, a nationally recognized Pumps in the School (PITS) Program in 14 high schools statewide (two less than the year before due to education program closures), and breastfeeding peer counselors (BFPC). WIC maintains state and local agency level breastfeeding coordinators (BFC) and hosts the Centers for Disease Control (CDC)/United States Breastfeeding Coalition (USBC) teleconference for the State of Hawaii.

WIC continues to contract with Parents And Children Together (PACT), one of Hawaii's leading private non-profit family service agencies, to provide technical support to the first BFPC placed at a community health center. PACT collaborated with Family Support Services of West Hawaii to provide BFPC training to their home visiting staff as well as staff from the Kona WIC Program and community partners like Alu Like (a service agency for Native Hawaiians) and Kona Community Hospital. BFPC can provide breastfeeding information to prenatal and postpartum WIC clients via clinic, home, and hospital visits.

WIC contributes breastfeeding data to the national Pediatric Nutrition Surveillance System (PedNSS) report, which represents low income residents in Hawaii. The 2009 Hawaii rate measuring any breastfeeding at 6 months was 41.3% an increase over 2008 (38.1%) and was better than the 2009 national rate of 26.9%. Because WIC serves low-income, high-risk women the rates for breastfeeding are expected to be lower than for the general population.

The University of Hawaii Medical School Residency Program in the third year curriculum provides three and a half hours (3.5) breastfeeding instruction for all pediatric residents and a two-hour session for all obstetric residents.

The Hawaii Breastfeeding Coalition (HBC) provides State leadership for breastfeeding promotion. The HBC expanded their website to include more specific breastfeeding information and resources, facilitating better communication between lactation health professionals and parents. They promote workplace lactation support by using "The Business Case for Breastfeeding" (BCB) resource kit. As a result of their efforts, several large employer groups have made changes to accommodate employees' need for support of breastfeeding after they return to work.

Hawaii's breastfeeding law protects women's ability to breastfeed and express milk, but only "encourages" employers to establish accommodation policies. The law protects women's right to breastfeed in places of public accommodation.

In 2009, the HBC initiated a discussion of the need for health insurers to consider including lactation consultant services and equipment as a covered benefit, and proposed incentivizing employer groups who implement the BCB. HBC developed teams to work on key issues related to breastfeeding in Hawaii: Business, Mother Support, Legislative, Health Care, and Breastfeeding Awareness.

HBC was a key stakeholder in the development of a proposal submitted by DOH Healthy Hawaii Initiative (HHI), chronic disease prevention program to the CDC ARRA-funded Communities

Putting Prevention to Work (CPPW) State Initiative program. The grant project focuses on changing policies in hospital maternity programs to sustain breastfeeding after birth and provide the support to apply for "Baby Friendly" hospital certification. Currently, Kaiser Permanente Hospital is the only designated "Baby Friendly" hospital in the state.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Contract to provide breastfeeding education and support to high-risk pregnant women statewide.		X	X	
2. Provide breastfeeding promotion, education and support to WIC pregnant and postpartum clients.		X	X	
3. Support, encourage and advise hospitals in moving towards changing organization policies and practices to qualify for “Baby Friendly Designation”.				X
4. Provide information on breastfeeding to the public and professionals.			X	X
5. Provide information on breastfeeding to the public and professionals.				X
6. Collect breastfeeding data.				X
7. Plan major statewide breastfeeding promotional events and campaigns.				X
8. Pursue a position in Department of Health to promote breastfeeding across all departmental programs.				X
9. Conduct training and certification for breastfeeding counselors and lactation consultants.				X
10.				

b. Current Activities

DOH HHI was awarded CDC funding for the Baby Friendly Hawaii project in February and will assist 11 hospitals to modify policies/systems toward becoming Baby Friendly certified. The 2 year grant provides staff education and consultant services. Several neighbor island hospitals have initiated discussions to adopt more baby friendly practices and policies.

WIC will promote the World Breastfeeding Event in August 2010 with the theme "Just Ten Steps: The Baby Friendly Way!"

The new WIC food package implemented in October 2009 increases incentives for exclusively nursing mothers and decreases the amount of formula. Exclusively nursing mothers get the greatest variety and amount of food.

WIC State Agency paid for 11 staff to attend a 45-hour Certified Lactation Consultant training. To date, eight have passed the exam. WIC provided a 6-hour staff training on the new food packages, communication skills, and the importance of breastfeeding one month postpartum. WIC continues to host the CDC/USBC teleconference calls.

WIC received increased BFPC funds. The PACT trainer recruited and trained 4 candidates. PACT also collaborates with Early Head Start on breastfeeding and BFPC program promotion.

WIC will fund a half-time BFPC for the Kauai District Health Office (DHO). The remaining half time position will be funded through a CDC ARRA-funded CPPW Community Initiatve grant received by Kauai DHO to prevent obesity.

c. Plan for the Coming Year
Final data for births in 2006 (2009 reported data) will be provided in next year's report from the NIS. Objectives for this performance measure were set to increase at 1% each year. Objectives will not be revised until a clear trend emerges.

Hawaii has a history of strong breastfeeding initiation rates. The following activities will address the efforts to increase breastfeeding duration rates as well as exclusive breastfeeding. A previous internal chart review of 100 WIC records from a local hospital indicated that over 50% of pregnant women who expressed the desire to breastfeed upon admission were using formula by discharge supporting the need to improve hospital policies and practices to promote breastfeeding.

The DOH will work with HBC on the "Baby Friendly Hawaii" project to assist maternity hospital programs to modify organizational policies and practices to help new mothers sustain exclusive breastfeeding of their infants using the resources of the CDC ARRA-funded CPPW state initiative grant.

Kona Community Hospital in partnership with the Early Head Start (EHS) program started a pilot project to promote breastfeeding through infant's first birthday. In place of free baby bags with formula, mothers are given a bobby pillow, a breastfeeding instructional DVD, tips for Dads on how to support breastfeeding, and contacts for lactation support. EHS home visiting programs provide targeted infant feeding education and support prenatally to mothers. The program is supported with funding by HMSA, the state's largest health insurer, and the Big Island Perinatal Health Disparities Project.

WIC will collaborate with the Kauai DHO to implement provisions of their CDC ARRA funded grant to establish a full-time BFPC position.

WIC will continue to support the efforts of the HBC to assure employees are provided adequate pumping breaks and assure that breastfeeding women are protected from discrimination. WIC will continue to encourage the establishment of lactation rooms at each DOH building.

The Title V programs will continue to provide breastfeeding education and support to high-risk pregnant women. DOH will explore external funding opportunities that would secure a breastfeeding professional position across all programs in the near future.

WIC plans to train additional BFPC and expand BFPC services to include more local agency staff, visit clients in hospital maternity wards and at home after delivery, continue to offer training for WIC and community partners, expand its breastfeeding incentive program and the breast pump loan program.

WIC activities around World Breastfeeding Week will focus on increasing awareness and support for the benefits of breastfeeding.

WIC will continue promoting the benefits of the new food package, particularly for exclusively nursing mothers. Because the new package decreases the amount of formula for partially nursing mothers, WIC must continue to ensure these women do not stop breastfeeding to receive more formula.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	98	98	98	98	98.4
Annual Indicator	97.6	98.3	98.1	98.9	87.6
Numerator	17417	18573	18725	19170	16470
Denominator	17839	18888	19085	19377	18807
Data Source				Hawaii NHSP	Hawaii NHSP
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	98.4	98.4	98.4	98.4	98.4

Notes - 2009
For 2003-2005, the denominator is from vital records of live births minus deaths before 24 hours. Beginning in 2006, the denominator is from vital records of live births minus deaths before screening. The numerator is the number of infants screened before discharge, as reported by hospitals to the state Early Hearing Detection and Intervention (EHDI) program. Data is reported by calendar year to the Centers for Disease Control and Prevention. Data for CY 2008 was updated. Data for 2009 is preliminary.

Notes - 2007
For 2002-2004, the denominator is from vital records of live births minus deaths before 24 hours. Beginning in 2005, the denominator is from vital records of live births minus deaths before screening. The numerator is the number of infants screened before discharge, as reported by hospitals to the state EHDI program for use in annual calendar year (CY) reports to the Centers for Disease Control and Prevention. Data for CY 2006 (Jan-Dec) were updated. Data for CY 2007 (Jan-Dec) are preliminary.

a. Last Year's Accomplishments
The 2009 data is preliminary and will be updated next year. The 2008 indicator was 98.9%, which met the objective of 98%.

The Newborn Hearing Screening Program (NHSP) began in 1990 through a law mandating that the DOH develop methodology to establish a statewide program for screening of infants and children age 0-3 years for hearing loss. Screening began in 2 hospitals in 1992, was provided in all birthing facilities by 1999, and is now part of standard newborn care in Hawaii.

Amendment of the law in 2001 mandated screening all newborns for hearing loss and reporting screening results to the DOH. In 2003, NHSP began outreach to homebirth families statewide through midwives. Hearing screening is now available to families statewide, regardless of birth location. As of November 2006, all hospitals have both otoacoustic emissions and auditory brainstem response screening capability and have backup equipment.

The number of hospitals delivering and screening babies remains at twelve. Eleven of the twelve hospitals transfer child-specific data to the state NHSP HI*TRACK data system. The remaining hospital submits annual aggregate data to NHSP; however, this information is not adequate for state follow-up purposes. Discussion continues with the hospital regarding child-specific data submission.

NHSP continued to work closely with hospitals and medical home providers in 2009. NHSP worked with hospitals monthly to reconcile state data against hospital delivery logs and track follow-up needs.

The NHSP protocol was updated to include calls to doctors for assistance when infants were referred to NHSP for follow-up. If an infant missed or failed inpatient or outpatient screening and a referral was made to NHSP by the hospital screener, NHSP staff contacted both the parents and infant's primary care physician (PCP) to follow-up. All screening or evaluation reports were sent to infant's PCP.

With the addition of two new staff, NHSP was able to provide parent support to families with children who failed hearing screening or who had confirmed hearing loss. Collaboration with birthing hospitals was strengthened to ensure timely and more accurate data transfer from the hospitals.

NHSP began participating in the National Initiative for Children's Healthcare Quality (NICHQ) Learning Collaborative B, "Improving the System of Care for Children and Youth with Special Health Care Needs: Newborn Hearing Screening Programs". The Collaborative used a quality improvement model of testing or adapting changes before implementing changes throughout an organization. Participants include NHSP staff, newborn screening staff from a hospital on Kauai and the tertiary pediatric hospital on Oahu, American Academy of Pediatric Hawaii Chapter Early Hearing Detection and Intervention (EHDI) Champion pediatrician, and Children with Special Health Needs Branch (CSHNB) Chief.

A NHSP Advisory Committee meeting was held in July 2009. Issues about lost to follow-up and strategies to improve lost to contact were discussed. NHSP worked with birthing hospitals and collaborated with the Newborn Metabolic Screening Program to ensure that contact information of child's primary care physician and primary care provider was entered in the NHSP database system.

NHSP collaborated with the Early Intervention Section (EIS) in developing a method to identify children receiving early intervention (EI) services. At the time of enrollment in an EI program, parents are asked to sign a consent form to share information with NHSP. The EIS database of children whose families signed the consent can be electronically matched to the NHSP database to identify children receiving EI services who had been lost to follow-up/documentation for newborn hearing screening or evaluation. The data sharing and consent form allows NHSP to identify and contact the EI care coordinators to ensure that children received appropriate diagnostic audiological evaluation and follow-up services.

NHSP, with the support of the CSHNB Research Statistician, continues to monitor the percentage of children who are lost to follow-up/documentation at all stages and to document progress.

Administrative rules for NHSP were drafted and are now in the lengthy process of being approved.

Funding from the MCH Bureau for the Baby Hearing Evaluation and Access to Resources and Services (Baby HEARS)-Hawaii project supported the CSHNB/NHSP efforts to improve newborn hearing screening and follow-up in Hawaii during
20

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Conduct newborn hearing screening at all birthing hospitals in Hawaii.	X	X	X	X

2. Assist with follow-up for rescreening, audiological assessment, or risk for late onset hearing loss.	X	X		X
3. Monitor hospital newborn hearing screening rates and assist in addressing screening barriers.				X
4. Homebirth newborn hearing screening outreach and monitor impact on screening rates.		X		X
5. Software/technical assistance to birthing hospitals to facilitate reporting of screening results.				X
6. Develop database linkages to identify infants who may not have received hearing screening.				X
7. Develop/disseminate public awareness materials on early hearing detection and intervention (EHDI).				X
8. Education/training for hospital screening staff, audiologists, and other providers about EHDI.				X
9. Promulgate administrative rules for EHDI that are consistent with state newborn hearing screening law.				X
10.				

b. Current Activities

Hearing screening continues in all birthing facilities. NHSP assists with follow-up, monitors hospital screening rates, and provides technical assistance. HI*TRACK software is provided at no cost to hospitals.

The HI*TRACK software is upgraded at the NHSP office. The new version allows easier tracking of infants who need outpatient screening, evaluation and intervention.

Newborn Hearing and Metabolic Screening Programs coordinate quality assurance efforts and provide brochures/letters to home birth families through Birth Registrars and periodic mailings to physicians, midwives and naturopaths.

NHSP continues to participate in the NICHQ Learning Collaborative B. Two activities, the family guide and stork card, piloted in the Learning Collaborative, will be implemented statewide.

The hospital newborn hearing screening coordinators committee met in May, the providers committee will meet in June and the EHDI Advisory Committee will meet in July of 2010. The purposes of these stakeholders meetings are to strengthen collaboration and to discuss improving the system of services for the identification and intervention of infants with hearing loss.

NHSP will contract a Pediatric Audiology Clinic to provide ABR diagnostic services on Oahu and on two neighbor islands, where such service is insufficient or is unavailable.

c. Plan for the Coming Year

Newborn screening will continue in all birthing facilities. NHSP will assist with follow-up for infants who need rescreening or referrals for audiological assessments and intervention, as well as for infants being monitored for late onset of hearing loss.

Data collection and tracking procedures will be improved. A higher version of HI*TRACK database system will be implemented in all birthing hospitals. It will enable more efficient data transfer and better tracking of missed screening or lost to follow-up. The program will continue linkages with newborn metabolic screening and early intervention databases to help locate children who are otherwise lost to follow-up/documentation. Efforts to involve primary care providers, other public health programs and Part C early intervention providers in the follow-up process will be expanded.

Newborn hearing screening/follow-up rates will continue to be monitored. Strategies will be implemented to help hospitals further address screening barriers and decrease loss to follow-up/documentation at the screening stage of the EHDI process. NHSP and the Newborn Metabolic Screening Program will continue joint quality assurance activities. NHSP will continue contacting hospitals monthly to reconcile state data against hospital delivery logs. New strategies will be established to improve outreach to homebirth families.

Educational sessions/training will continue to be provided for hospital newborn hearing screening staff, audiologists, physicians, early intervention, and other providers. Strategies will be implemented to help reduce lost to follow-up/documentation at the evaluation and intervention stages of the EHDI process.

NHSP will continue to disseminate public awareness materials to inform parents, early intervention providers, and health professionals about early hearing detection and intervention. Hospital screener training materials will be disseminated.

NHSP will continue to provide parent support to families with children with hearing loss at the diagnostic and intervention stages of the EHDI process and will continue to facilitate statewide family support activities. Support to hospitals in the screening, tracking and data input system will be strengthened. The part-time Audiologist continues to assist with quality assurance and provide audiological consultation. Loaner equipment and lending library materials will be disseminated as needed.

The EHDI Advisory Committee and subcommittees will continue to meet and provide input on state program policies and procedures.

The process to establish administrative rules will continue.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	2.3	1.8	1.8	1.4	3.7
Annual Indicator	2.1	2.2	3.9	2.5	2.5
Numerator	6343	6343	11545	6815	6815
Denominator	295999	292999	293374	273914	273914
Data Source				Hawaii Health Survey	Hawaii Health Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	3.7	3.7	3.7	3.7	3.7

Notes - 2009
The data is from the Hawaii Health Survey administered by the Department of Health, Office of Health Status Monitoring. It is a continuous statewide household survey of health and socio-demographic conditions. The HHS started in 1968. In 1996, the survey converted to a telephone survey that focused on respondents 18 years of age and older that was knowledgeable about their household in order to collect information on persons of all ages living in the household. In 2004, 6,789 household respondents were interviewed and information on a total of 19,669 household members was obtained. This information is then weighted to reflect statewide estimates excluding households without telephones, Niihau, those living in group quarters, and those that are homeless. The survey provides demographic information for observing population changes during the intercensal decade. It provides state and sub-area estimates of gender, age, income, race, education, household size, insurance status, health status, morbidity, and food security.

Notes - 2008
Hawai‘i State Department of Health population estimate. The data is by calendar year and comes from a state-wide random sample survey and is subject to sampling variability. Data from the 2006 and 2008 surveys are not yet available.

Notes - 2007
Hawai‘i State Department of Health population estimate. The data is by calendar year and comes from a state-wide random sample survey and is subject to sampling variability. Data from the 2006 and 2007 surveys are not yet available.

a. Last Year's Accomplishments
Data for 2008 indicates 2.4% of children 0-17 years of age are uninsured, an estimated 6,815 children. The uninsured rate for children in Hawaii has always been relatively low with little change.

The thrust of the Title V agency's efforts to decrease the percentage of children without health insurance is infrastructure building services, conducted in partnership with other State and community agencies.

The Title V agency continues to use the Hawaii Health Survey (HHS) data, an annual population-based residential telephone survey, because it currently provides the best consistent estimate of uninsured children. The same module of questions related to health insurance has been asked in the HHS since 1998 providing a degree of consistency and comparability.

Hawaii Covering Kids (HCK) is a statewide initiative that identifies, enrolls and retains eligible children and youths in health insurance programs. HCK collaborates with federal, state and community agencies to conduct outreach activities and works with the Hawai‘i State Department of Human Services Med-QUEST Division (DHS Med-QUEST), the state's Medicaid agency, to improve policies and procedures that increase enrollment of children and youths in public health insurance. The Hawaii Primary Care Association began the project in 1999 with Robert Wood Johnson Foundation start-up funding. HCK is currently funded by Hawai‘i State Department of Human Services Med-QUEST Division and three foundations.

Over the past 10 years, HCK has been extremely successful in leading and initiating efforts to increase children's enrollment into Medicaid and other private insurance sources through the work of its five task forces (Process Simplification, Media and Public Information, Identification and Outreach, Training and Public Education, and Evaluation) and ad hoc committees. HCK also maintains a user-friendly website with updated eligibility information about children's health insurance programs and DHS Med-QUEST forms. Easy access to updated information includes, Guidelines for QUEST and Medicaid. A web page has been developed specifically for recently Laid-Off Workers. The Child insurance web page, the Facebook page, and advertisement on the Hawaii High School Athletic Association webpage are continuously updated.

The Children's Health Insurance Program Reauthorization (CHIPRA) was signed into law on February 4, 2009, and is effective April 1, 2009 to September 30, 2013. The law allows Hawaii to cover additional children and youths who are eligible but not enrolled.

The Simplification Task Force outlined Hawaii's Med-QUEST procedures and developed plans to eliminate application and renewal error rates and minimize the eligibility documentation requirement to assure eligible enrollees easily qualify for Medicaid and CHIP programs and meet the new Centers for Medicare and Medicaid Services (CMS) Payment Error Rate Measurement (PERM) program requirements.

As the cost of private health insurance had increased, Hawaii responded by revising income eligibility levels to be able to cover more families. Hawaii expanded CHIP to provide free health insurance to children up to 19 years of age with family incomes up to 300% of the Federal Poverty Level (FLP). (Prior to April 1, 2008, families making up to 250% FPL received free health insurance for their children and families making between 251-300% FPL paid reduced monthly premiums.).

Hawaii uses State-only funds to provide free medical insurance for lawful permanent resident children and youths (possessing a "green card") living in the U.S. less than five years, refugees, and those born in the Marshall Islands, Federated States of Micronesia and Palau. As of December 30, 2008, there were 20,805 enrolled in CHIP and 3,622 enrolled in the Immigrant Children's program. The federal government provided matching funds for these children through the federal CHIP Reauthorization law beginning 02/04/09 thereby saving the State $2.7 million annually.

HCK continues to inform parents and guardians about free health insurance through public and private schools, WIC, Head Start, organizations helping grandparents raising grandchildren, community groups participating in local fairs, legal aid offices, unemployment offices, youth clubs, and child care centers.

All Title V purchase-of-service contracts continue to require appropriate referrals for uninsured children who are eligible for public health insurance.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Develop improved methodology for measuring uninsured children.				X
2. Develop and implement new strategies for outreach to enroll uninsured children				X
3. Develop and implement, in collaboration with the state Medicaid agency new strategies to simplify the application and enrollment for the program.				X
4. Require Title V contractors to refer eligible uninsured children for insurance coverage.				X
5. Provide updated and timely user-friendly information and application materials to families regarding Medicaid program changes.			X	X
6. Ensure collaboration between the state Medicaid agency, state health insurance plans, policymakers, and community service agencies to assure coverage for uninsured children.				X
7. Advocate for legislation to support expanding health insurance				X

coverage for gap group children.				
8. Support the leadership efforts of Hawaii Covering Kids to coordinate and assure statewide efforts continue to identify, enroll and retain children in health insurance plans.				X
9.				
10.				

b. Current Activities

HCK continued outreach to laid-off workers with children by working with the State's Rapid Response Team, which provides information on services for large groups of laid-off workers due to company closures and state reduction in force (RIFs); posting a link on the State Department of Labor and Industrial Relations web page; and printing a message about children's health insurance on unemployment checks beginning May 2009. HCK health insurance information flyers are published in 21 languages to reach the multiethnic population.

HMSA, the state's largest medical insurer, has a Children's Plan with limited benefits for $55.00 a month per child.

Title V contracts require appropriate referrals for uninsured children eligible for Medicaid and CHIP. Out stationed eligibility workers are employed by community health centers and hospitals with Med-Quest funds.

The Hawaii Legislature celebrated HCK's tenth anniversary and recognized the project's accomplishments. Since it began, there has been a net gain of over 40,000 kids in Hawaii's public health insurance programs.

HCK's statewide postcard mail-out campaigned was launched to inform families about QUEST and QExA for eligible children and youths. It is a strategy to reach parents affected by the downturn who are unfamiliar with public health insurance programs. The goal was to mail approximately 508,000 Hawaii addresses during the one-month outreach activity. The two-sided image of the postcard can be viewed on the Facebook page.

c. Plan for the Coming Year

Data for this measure will be updated in next year's report. Hawaii continues to draw closer to the Healthy People 2010 goal of complete coverage for all. Objectives will be revised since it is unlikely Hawaii will reach zero uninsured children by 2010, especially with the state's economic downturn.

The impact of the State's poor economic conditions has resulted in increased unemployment. Because the main source of coverage in Hawaii and the U.S. as a whole is employment-based insurance, the coverage situation has deteriorated as unemployment has risen. Future data may begin to reflect this impact.

Cuts to state-funded safety net services and positions have begun and will likely continue into the next fiscal year as the budget deficit mounts. The impact of budget cuts on the State Medicaid program is unclear at this time.

The Title V agency will continue to work in partnership with HCK and stakeholders to expand outreach and enrollment of uninsured children and youth. All Title V purchase-of-service contracts will continue to require that eligible uninsured children be referred for appropriate health insurance coverage.

HCK work plan through October 2011 includes three main objectives which are to: 1) coordinate and conduct outreach activities; 2) simplify applications and renewal processes; and 3)

coordinate existing health insurance programs.

Outreach activities will utilize a variety of media resources which may also include, movie theater and shopping mall advertising during November-December; radio and television advertising focusing on Asian and Latino immigrants and Pacific Island immigrants; focusing on Pacific migrant service organizations, faith-based groups, and ethnic Chambers of Commerce to continue outreach for newly arrived immigrants and Pacific migrants; and organize pharmacy outreach campaigns. HCK will contact the Small Business Resource Center and Small Business Association to distribute information to self-employed workers. A Rural Radio Campaign will be implemented to reach families who live in areas outside the city on Honolulu simultaneously with one postcard mail-out. The MedQUEST annual census tract enrollment data will be combined with the Department of Education school lunch data to identify gap areas.

The HCK continues to identify barriers and solutions to the application and renewal process to increase a seamless transition of health insurance for children. The task forces continues to covert Med-QUEST forms into typeable PDFs, conduct training to out stationed eligibility workers at community health centers and hospitals, Med-QUEST supervisors, and conduct community training workshops about completing MedQUEST's applications and renewal forms.

The Evaluation Task Force's goal is to convert Med-QUEST's annual census tract enrollment data to Excel spreadsheets and combine it with Department of Education school lunch data to create maps and determine geographic gaps for outreach by October 2010.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		22	22	21	20
Annual Indicator	22.4	22.4	21.5	21.4	22.1
Numerator	3500	3500	3215	3447	3812
Denominator	15624	15624	14952	16106	17252
Data Source				Hawaii WIC Program	Hawaii WIC Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	19	18	17	17	16

Notes - 2009
Data is from the Centers for Disease Control (CDC) Pediatric Nutrition Surveillance System (PedNSS). Data for 2006 is not available due to data quality issues. The problems have been addressed by the WIC program and data has been resubmitted to CDC.

Notes - 2007

Data is from the Centers for Disease Control (CDC) Pediatric Nutrition Surveillance System (PedNSS). Data for 2006 is not available due to "data quality issues" according to the CDC. The problems have been addressed and data is being resubmitted. The current 2007 data is being reviewed by CDC.

a. Last Year's Accomplishments

The data for 2009 indicates 22.1% of WIC children age 2-5 years were overweight or at-risk for overweight. The 2009 data reflects an increase in the rate of overweight among WIC children. The estimate in Hawai'i remains significantly lower than the national average of 31.3% for states reporting PedNSS data. The increase in Hawai'i rates will be monitored.

WIC implemented a revised assessment tool to thoroughly assess a family's overall eating habits. The tool focuses on the quality of the individual's diet (not based on a 24 hour recall). Assessment revisions include non-nutrient dense beverages; whole versus refined grains; and energy dense, but not nutrient dense foods.

Counseling protocols for WIC children ages 2-5 years old who are at a BMI of 85th% or greater now include consistent recommendations and goals utilized in the Hawaii Pediatric Weight Management Toolkit. Nationally developed core messages for preschool moms include messages on role modeling, cooking/eating together and division of feeding responsibilities.

The new WIC food packages were implemented October 1, 2009 which include reduced fat milk, fruit/vegetables, whole grains, baby foods and soy alternatives to support healthier food choices. Training and educational materials were developed to assist participants in the selection and purchasing of lower-fat milk, fruits/vegetables and other new food items. WIC materials were developed to educate parents and caregivers on encouraging physical activity and provide suggestions that are developmentally appropriate for children ages 1-5. Staff and community partners were introduced to the changes at the WIC State Conference in May 2009. Participant education on the changes began in August 2009. WIC started distribution of the Sesame Workshop "Healthy Habits for Life" DVD kits to promote healthy weight for children. The national curriculum focuses on 3 behaviors: physical activity, grocery shopping, and anytime vs. sometime foods. The curriculum uses motivational interviewing and stages of change to customize the discussion.

Title V will continue to monitor the BMI data reported annually by the contracted providers for primary care services for the uninsured.

As part of the Title V Needs Assessment, child obesity was identified as a continuing state priority issue. Stakeholder input was collected from a survey distributed in 2009.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide education and support on appropriate dietary practices and physical activity.	X			
2. Assess weight and height of children every 6 months at all WIC certifications.	X			
3. Provide information on dietary guidelines to professionals and the public.		X		
4. Implement action plans related to diet and physical activity.	X			
5. Provide training for WIC/pediatric providers to improve weight related behaviors of families with young children.				X
6. Collect data on BMI on WIC low-income children as part of the				X

PedNSS.				
7. Collect data on children's BMI from the Community Health Centers.				X
8. Develop and implement the Statewide Obesity Prevention Plan including sections concerning young children.				X
9. Promote healthy lifestyles through public education campaigns.			X	
10.				

b. Current Activities
WIC education supports the messages of less fat and more fiber intake. Reduced fat milk is required for adults and children age 2 years or younger. To promote healthy weight, WIC distributed approximately 30,000 of "Healthy Habits for Life" kits to families.

The mandatory state furloughs and hiring freezes negatively impacted caseload by 1000-2000 participants/month when WIC applicants increased due to the economic downturn. Some contracted agencies absorbed caseload, but there are no options for certain parts of the state.

Title V will continue to monitor the BMI data reported by the contracted primary care providers and ensure they discuss prevention education and strategies.

Activities of the Physical Activity and Nutrition (PAN) Coalition, renamed Nutrition and Physical Activity Coalition (NPAC), include developing curricula/educational information, promoting nutrition/physical activity guidelines and policies, and supporting breastfeeding.

Child obesity was selected as a state priority in the Title V needs assessment; a problem analysis was conducted to evaluate progress, identify major risk/protective factors, assess the existing services, and strategies were identified at a statewide stakeholders meeting in November 2009.

c. Plan for the Coming Year
WIC will collaborate with Head Start State Collaboration Office on a Childhood Obesity symposium to be held in September 2011 and with the DOH Healthy Hawaii Initiative and other community partners in revising the State Physical Activity and Nutrition Plan. WIC continues to give families the Sesame Workshop's "Healthy Habits for Life" kit and will explore coordination with early child care centers to ensure a consistent message.

WIC will purchase a children's book "Move 'Um" developed by the Honolulu Community Action Program. WIC will develop a combined literacy and physical activity curriculum that uses this book. The curriculum may be used at WIC clinics and would be offered to community partners.

The revised WIC food packages now offer whole grains, fruits/vegetables, soy products, and increased variety of canned fish. WIC continues to highlight and encourage consumption of these foods as part of a healthy lifestyle for the whole family.

Approximately half of pregnancies in the country are unplanned. Unplanned pregnancies can be a leading cause for large for gestational age infants due to maternal greater than ideal weight gain. Local agency staff will be trained to strengthen efforts in counseling postpartum women regarding healthy lifestyles.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		8	8	7	6.8
Annual Indicator	8.4	9.4	8.4	8.5	8.5
Numerator	1440	1716	1548	1592	1592
Denominator	17233	18300	18504	18626	18626
Data Source				Hawaii PRAMS	Hawaii PRAMS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	6.5	6.2	5.9	5.9	5.9

Notes - 2009
Data for this measure comes from the Pregnancy Risk Assessment Monitoring System (PRAMS) and reflects data from births that occurred in the specified year. Data for the year 2008 is the latest available data for women who smoke in the last 3 months of pregnancy and was carried forward to 2009.

Notes - 2008
Data for the year 2007 is the latest data available.

Notes - 2007
This is a new National Performance Measure added in for the 5-year reporting period, FY 2006-2010.

Data for this measure comes from the Pregnancy Risk Assessment Monitoring System (PRAMS). The Hawaii Department of Health (DOH) started PRAMS in June 1999 as a pilot project. The year 2000 is the first full year of PRAMS data. Data for the year 2006 is the latest available data for women who smoke in the last 3 months of pregnancy.

a. Last Year's Accomplishments
Smoking is the single largest known preventable risk factor for poor pregnancy outcomes. The 2008 data (latest available data) indicates 8.5% of pregnant women reported smoking during pregnancy. The State objective of 7.0 % and the Healthy People 2010 objective of 1% were not met.

The 2004-06 Hawaii PRAMS data shows an average of 21% of women reported smoking just before pregnancy. A substantial percent of women stopped smoking during their pregnancy; however 8.6% of women continued to smoke during pregnancy. Sadly, 64% of women who smoked before becoming pregnant reported smoking in the postpartum period when infants can suffer respiratory ailments and other health problems related to second hand smoke. Maternal characteristics associated with smoking during pregnancy are: under 25 years of age; having Medicaid insurance; unmarried; of Samoan or Hawaiian ethnicity; Hawaii Island resident; lower education levels; and, pregnant multiple times.

Title V continued to administer the Perinatal Health Programs for Department of Health (DOH). The Perinatal Support Services (PSS) programs provided outreach, screening, health education,

case management and care coordination for high-risk pregnant women. PSS providers screened and assessed smoking behaviors using brief intervention (BI) and motivational interviewing (MI) methods.

The Baby Substance Abuse Free Environment (S.A.F.E.) Program, which provided services to substance-using pregnant women, screened for smoking behaviors that would later reveal other substance abuse problems. State funding cuts resulted in the programs' closure in June 2009.

The Healthy Mothers Healthy Babies (HMHB) Coalition provides system building support to improve statewide perinatal services through advocacy and networking. HMHB also manages the State Pregnancy Warmline and website. With funding from the Hawaii Community Foundation, HMHB collaborated with the Kapiolani Medical Center for Women and Children (KMCWC) smoking cessation team to conduct smoking cessation workshops for health providers at KMCWC, neighbor island hospitals and medical centers.

The DOH Basic Tobacco Intervention Skills Certification Program was established to increase screening and smoking cessation counseling skills of health professionals using the 5 A's Tobacco Cessation Counseling Guidelines (Ask, Advise, Assess, Assist, and Arrange), a brief intervention technique.

The WIC Clinic staff continued to screen pregnant women and mothers using the 5 A's guidelines to assess smoking cessation readiness and provide referrals as needed. WIC referred pregnant and parenting women to the DOH statewide Tobacco Quitline and community health centers for smoking cessation classes and interventions.

The federal Healthy Start Big Island Perinatal Disparities program (BIPDP) is implemented through a contract with the Family Support Services of West Hawaii (FSSWH) on the island of Hawaii. The program is designed to decrease the incidence of poor birth outcomes and includes screening for smoking and other risk behaviors.

The Perinatal Addiction Treatment of Hawaii (PATH) Clinic on Oahu provides comprehensive prenatal/postnatal care to substance using pregnant women. PATH provides both clinical and social support services and is administered by the University Department of Obstetrics and Gynecology. The PATH Clinic received funding to provide smoking cessation classes for 3 years that incorporates a holistic approach to cessation using methods such as acupuncture to reduce cravings/withdrawal symptoms, perinatal yoga and Qi Gong for relaxation and meditation. The funding is provided by the Hawaii Tobacco Trust Fund which is financed by the 1998 Master Settlement Agreement (MSA) with tobacco companies.

The Prenatal Smoking Workgroup was established as result of the 2005 Title V needs assessment to convene key public and private smoking prevention and perinatal stakeholders to share information and collaborate on policy and program planning. The group meets quarterly, co-chaired by Title V staff and an Ob-Gyn who is part of the DOH advisory team administering the Tobacco Trust Fund.

Hawaii is one of a few states that continues to use a portion of the MSA funds for tobacco prevention. The Hawaii efforts are directed at large scale community norm changes that include policy change, community education, media/countermarketing, resulting in the 5th lowest smoking rate among adults in the U.S.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Conduct the Pregnancy Risk Assessment Monitoring Survey (PRAMS) to collect, analyze and disseminate data on tobacco				X

use before, during and after pregnancy.				
2. Execute and administer contracts for perinatal support services to high-risk pregnant women.	X	X		X
3. Execute and administer contracts for outreach and pretreatment services to pregnant women using tobacco and other drugs.	X	X		
4. Provide outreach and support services during pregnancy and 2 year interconception period through the Hawaii County Perinatal Disparities Grant for risk groups. Services address risk factors for tobacco and other substance use.	X	X		
5. Execute and administer contracts to enhance the statewide perinatal system of care through assessment and advocacy; pregnancy resource referral and information (phone line and website); and, perinatal provider education and training.		X	X	X
6. Provide screening and referral for WIC low income perinatal clients who use substances including tobacco.		X		
7. Provide screening and referral for WIC low income perinatal clients who use substances including tobacco.		X		X
8. Continue needs assessment efforts through the Prenatal Smoking Workgroup to promote strategies that work in smoking cessation for women before, during and after pregnancy.				X
9. Collaborate on effective strategies to reduce smoking during and after pregnancy as part of the State Tobacco Use and Prevention Plan (e.g. media, counter marketing campaigns, policies for smoking prevention and control use).				X
10. Operate the statewide toll-free smokers Quitline.			X	X

b. Current Activities

Title V staff continues to manage perinatal health programs, participate in smoking cessation activities such as co-chairing the Prenatal Smoking Workgroup, and collaborate with the Tobacco Prevention and Education Program (TPEP), the lead agency for tobacco prevention in DOH.

TPEP developed a bus card and poster, adapted from the American Legacy Foundation, "Great Start" campaign that features a developing fetus smoking a cigarette in the womb. The message targets pregnant women to quit smoking. The posters will be distributed statewide and through PSS providers. A brochure titled, "Stop Smoking For a Healthy Baby," will also be distributed to pregnant women through perinatal healthcare providers.

In March, HMHB sponsored a 2-day workshop at University of Hawaii, with a leading tobacco researcher and tobacco cessation specialist. The workshop provided tools for mental health professionals, including MCH providers, to address smoking cessation for high-risk individuals with co-occurring mental health conditions.

The March 2010 Prenatal Smoking Workgroup meeting considered supporting legislation to have Medicaid reimburse tobacco cessation counseling, but reconsidered given the poor economy. Smoking cessation activities supported by the Tobacco Trust funds shall continue. Despite enormous pressure, tobacco prevention advocates were successful at stopping the diversion of Tobacco Trust Funds to cover the state budget shortfalls during the legislative session.

c. Plan for the Coming Year

Data for PRAMS will be updated in the next year. The objectives for this measure have been set to decrease 5% annually to assure progress in achieving the Healthy People 2010 Objective. The Title V staff administers PRAMS and will publish a new eight year PRAMS Trend report in 2010.

Title V efforts will continue to screen pregnant women for tobacco use through PSS programs. Pregnant women that are smoking will continue to receive BI and MI in each trimester of pregnancy and the post-partum period as needed. With PRAMS data showing the smoking rate increasing after delivery, strategies to decrease the rate for smoking relapse in the post-partum period will be an area of focus for the Prenatal Smoking Workgroup in addition to the effects of second hand smoke on infants/children.

A planning group has been formed to develop a panel on perinatal issues and the dangers of second hand smoke for the next statewide tobacco prevention conference in September.

The current PSS contracts for high-risk pregnant women ends on June 30, 2011 and a new request for proposal process will be announced for future services. Perinatal health programs to address high-risk health behaviors in pregnancy will need to improve program integration with other community perinatal services to increase coordination and utilize dwindling resources more effectively.

Like many community providers, services like HMHB and the PATH Clinic face the threat of funding cuts in the future due to the poor state economy. HMHB is exploring innovative and more cost-effective social media outreach approaches and plans to implement, TEXT4Baby, a national initiative to promote healthy pregnancy behaviors through mobile phone text messages timed to the pregnant woman's expected due date. The PATH Clinic will continue to provide smoking cessation programs utilizing a holistic approach using Tobacco Settlement funds.

The Big Island Perinatal Disparities (BIPDP) program providers will continue to offer tobacco cessation services to high-risk pregnant women with federal funds allocated exclusively for the Big Island.

The Prenatal Smoking Workgroup will continue to meet and discuss opportunities to increase public awareness on the dangers of smoking in pregnancy, the availability of smoking cessation resources for pregnant women and their families, and related legislation and policies.

WIC will continue to screen clients for tobacco use and provide appropriate referral as required.

DOH Healthy Hawaii Initiative (HHI), chronic disease prevention program, was awarded a CDC ARRA-funded Communities Putting Prevention to Work State Initiative program to expand promotion efforts for the State Tobacco Quitline.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	9	9	8	8	7
Annual Indicator	8.2	8.2	10.6	10.6	11.4
Numerator	20	20	26	26	28
Denominator	243426	243656	244971	244971	244971
Data Source				Hawaii State Vital records	Hawaii State Vital records
Check this box if you cannot report the numerator because 1.There are fewer than 5 events			Yes	Yes	

over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	7	7	7	7	5

Notes - 2009
Due to the small number of suicide deaths, a three-year annual average is being reported. The reported data maybe too small to calculate reliable measures. Caution should be exercised in the use of the reported data.
Data is for resident population and is by calendar year. Data for the year 2008 was revised with an updated death data file. Data for the year 2009 is provisional. Population data based on U.S. Census Bureau, Population Estimates Program, "Annual Estimates of the Resident Population by Single-Year of Age and Sex for the United States and States: July 1, 2008" (SC-EST2007-AGESEX_RES) (May 1, 2009). Estimates for the 2009 population were not available from the Census bureau at time of this report so the prior year estimate was used in the determination of the indicator in 2009 is the same as was used in 2008 and reflects population estimates for youths aged 15 through 19 years of age in 2006-2008.

Notes - 2008
Due to the small number of suicide deaths, a three-year annual average is being reported. The reported data maybe too small to calculate reliable measures. Unstable measures are not useful in making decisions. Caution should be exercised in the analysis of the reported data.

Notes - 2007
Data is for resident population and is by calendar year. Data for the year 2006 was revised with an updated death data file. Data for the year 2007 is based on a provisional death data file. Population data based on U.S. Census Bureau, Population Estimates Program, "Annual Estimates of the Resident Population by Single-Year of Age and Sex for the United States and States: July 1, 2007" (SC-EST2007-AGESEX_RES) (May 1, 2008). Objectives were revised based on the FY 1999 indicator. Due to the small number of suicide deaths, a three-year annual average is being reported.

The reported data maybe too small to calculate reliable measures. Unstable measures are not useful in making decisions. Caution should be exercised in the analysis of the reported data.

a. Last Year's Accomplishments
Three-year averages were used to calculate the indicator for this measure because the numbers are small and vary substantially from year to year. The provisional data for the 2008-2009 indicator is 11.4. The state objective was not met. The rates have remained relatively stable and changes are not statistically significant.

The State Department of Health (DOH) lead for youth suicide prevention is the Injury and Prevention Control Program (IPCP), which maintains a suicide prevention coordinator position to coordinate programs to prevent the rates of youth suicide from rising.

The Hawaii Suicide Prevention Task Force (SPTF) formed in 2005 continues to be guided by the efforts of IPCP. The SPTF consists of over 50 multi-disciplined, public and private agency members interested in suicide prevention. Members include the state Department of Education (DOE), Honolulu Police Department (HPD), the University of Hawaii, the Title V agency, DOH Child and Adult Mental Health Divisions, Emergency Medical Services (EMS) and others. Title V is represented by the Adolescent Health Coordinator who sits on the Suicide Prevention Steering Committee which serves as an advisory group to the DOH and works on implementing the goals

and objectives for suicide prevention in the Hawaii Injury Prevention Plan.

The Hawaii Gatekeeper Training Initiative is a project that focuses on suicide intervention training for adult gatekeepers in the DOE, DOH, HPD, and other key agencies that impact significant numbers of youth in school and community settings. The objective is to increase the number of youth, youth workers and community people who are trained to recognize and assess the risk of an individual in crisis and provide suicide prevention first aid, thereby minimizing the suicide risk. The training initiative is funded by a $1.5 million grant from the federal Substance Abuse and Mental Health Services Administration (SAMHSA).

The 3-year training initiative began in 2008 and will continue through 2011 using the Applied Suicide Intervention Skills Training (ASIST) throughout the state to reduce the number of completed and attempted suicides among at-risk youth ages 10-24. Through this grant, a dedicated coordinator was hired in March 2009 and more than 1,000 individuals have been trained in the first aid response intervention to suicide ideation. The training is mandatory for the DOH mental health crisis phone line staff. To date there are 45 ASIST trainers in the state that have completed the Training for Trainers or T4T.

In February 2008, the DOE's 25 Peer Education Program (PEP) coordinators attended a presentation on suicide and suicide prevention and were later provided "Signs of Suicide" (SOS) training designed for intermediate and high school students. SOS provides students with skills to assist in the recognition of peers in the school setting who may be at-risk for suicide. The training also included other DOE resource teachers and educational specialists.

The second Suicide Prevention Conference was held in November 2008 with 328 participants attending workshops including: forgiveness training, cultural awareness presentations, and support group discussions. The National Center for Child Death Review (CDR) Director and the Title V agency's CDR Nurse Coordinator led a conference session. In coordination with the suicide conference, the Hawaii CDR Council sponsored a training the day before the conference to maximize the availability of its national resource speaker.

The DOH and DOE continue to support surveillance instruments on adolescent behavior including the Youth Risk Behavioral Survey (YRBS) for public high and middle school students. The survey includes questions on suicidal thoughts and behavior as well as protective factors. Compared to national YRBS high school student rates, Hawaii's youth had one of the highest rates for suicide ideation in the U.S.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide suicide prevention education to students and the community.			X	
2. Implement the suicide prevention recommendations of the 2005-2010 Hawaii Injury Prevention Plan.				X
3. Develop greater coordination and collaboration to address suicide prevention.				X
4. Identify suicide prevention strategies by reviewing information surrounding child deaths.				X
5. Provide training to promote healthy youth development and suicide prevention efforts.				X
6. Support the surveillance systems through administration of the YRBS in High School and Middle School students to collect student health data used for program planning.				X

7. Promote increased awareness and education of suicide as a health problem, remove the stigma, identify those at-risk and provide support to survivors.			X	X
8. Support continued research into evidence-based practices and secure resources to expand services.				X
9. Participate in Suicide Prevention Plan Steering Committee, Task Force, and sub-committee to address short and long term objectives in the plan with relation to adolescents.				X
10.				

b. Current Activities
Efforts continue to reduce the number of completed and attempted suicides among youth ages 10-24 years of age by training adult gatekeepers in key agencies to recognize and respond to youth who are at risk.

This year Hawaii will join a cross-site evaluation database of thirty other state/tribal sites that receive funds from SAMHSA for teen suicide prevention under the Garrett Lee Memorial Act. The Hawaii Gatekeeper Training Initiative will begin to track program activity related to the early identification of youth at risk for suicide, referrals for services, service linkages as well as other program outcomes. The administrative details and implementation plan are currently underway.

The SPTF plans to continue efforts to prevent youth suicide and reduce ideation rates. The Suicide Coordinator position that staffs the SPTF was recently vacated but was filled with a DOH employee formerly in the STD prevention program as a result of the state reduction in force action. State funding for youth suicide prevention programs was not affected by DOH program cuts.

SPTF efforts are focusing on building SP Task Force capacity for each of the neighbor island counties. A psychologist with the DOE was elected as the new chair of the SPTF.

The DOH IPCP is beginning work to update the Hawai‘i Injury Prevention Plan (HIPP), which includes a section on suicide.

c. Plan for the Coming Year
Title V continues to monitor data for teen suicide. Provisional data will be updated. Objectives are set for a 1% point reduction every two years based on the FY 2000 indicator.

The DOH IPCP is revising the state suicide data to update the Hawai‘i Injury Prevention Plan (HIPP) for 2011-2015. The Prevent Suicide Hawaii Task Force and other community-based groups will continue to work with IPCP to review data and provide input on strengthening infrastructure to prevent suicides. While the teen suicide rates have not increased significantly, trend data is showing that suicides are increasing in this state, particularly among those 50 and older. The plan will be published later in 2010.

The Hawaii Gatekeeper Training Initiative, funded by a SAMSHA grant, will continue. The goal is to train as many people as possible across the islands. In addition to the SOS training another curriculum used is SafeTALK, a 3-hour training on recognizing the signs of suicide and providing referrals to those at-risk. SafeTALK is often used to train HPD officers and other direct service agency personnel.

Announcements for trainings are made through email broadcasts and flyers that detail current training schedules statewide with instructions on how to register online for the trainings.

Efforts to build the neighbor island SP task force capacity are expected to continue. The Kauai

SP Task Force is focusing efforts on drug, alcohol and suicide prevention. Their "We Care" campaign includes town hall meetings to encourage community-based conversations around suicide prevention and ideation.

A public education and media campaign is being discussed as a key strategy to stem the increase in suicides. Hawaii SPTF members were encouraged by the results of a current media campaign on suicide prevention launched in Guam.

In 2009, 18.9% of Hawaii's high school youth reported seriously considering attempting suicide in the past year, a slight increase from 18.5% in 2007, putting Hawaii again as highest for suicide ideation. Nationally, the trend has been steadily decreasing from 20.5% in 1997 to 13.8% in 2009. The DOH and DOE will continue to support surveillance instruments on adolescent behavior including the Youth Risk Behavioral Survey (YRBS) for public high and middle school students. The survey will continue to include questions regarding suicidal thoughts and behavior as well as protective factors.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	87.5	88	88.5	89	89.5
Annual Indicator	89.3	88.5	89.5	84.7	88.5
Numerator	216	223	205	199	232
Denominator	242	252	229	235	262
Data Source				Hawai‘i State Vital records	Hawai‘i State Vital records
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	90	90	90	90	90

Notes - 2009
Data is for resident population and is by calendar year. Data for the year 2008 was revised with an updated birth data file. Data for the year 2009 is based on a provisional birth data file. There are three medical facilities considered to be tertiary care centers in Hawai‘i: 1) Kapi‘olani Medical Center for Women and Children, 2) Tripler Army Medical Center and 3) Kaiser Permanente Moanalua Medical Center. The determination of annual performance objectives beyond the year 2010 is on hold pending a comprehensive reassessment and critique of the indicator’s past performance, issues and resources affecting the measure, and the release on the new Healthy People 2020 objectives.

Notes - 2007
Data is for resident population and is by calendar year. Data for the year 2006 was revised with an updated birth data file. Data for the year 2007 is based on a provisional birth data file.

There are three medical facilities considered to be tertiary care centers in Hawai‘i: 1) Kapi‘olani Medical Center for Women and Children, 2) Tripler Army Medical Center and 3) Kaiser Permanente Moanalua Medical Center.

The determination of annual performance objectives beyond the year 2010 is on hold pending a comprehensive reassessment and critique of the indicator's past performance, issues and resources affecting the measure, and the release on the new Healthy People 2020 objectives.

a. Last Year's Accomplishments

Provisional data for 2009 indicate 88.5% of very low birth weight infants were delivered at facilities for high-risk deliveries and neonates. The objective was not met. Although the rate did increase from last year, the data is provisional. Hawaii is nearing the Healthy People 2010 objective of 90%.

Kapiolani Medical Center for Women and Children (KMCWC) a private, non-profit, tertiary care facility specializing in gynecological, obstetrical, newborn and pediatric care has the largest delivery service in Hawaii located on the island of Oahu. KMCWC is the only hospital providing Level III-B care in the western Pacific region with a 46 bed Neonatal Intensive Care Unit (NICU). According to KMCWC certificate of need application, approved in May 2009 by the Statewide Health Coordinating Council, proposed plans for 24 additional NICU beds to 70 will accommodate the community's long term needs. The increase of NICU beds are necessary as part of the overall plan to create single-rooms for the NICU. The proposed state-of-the-art technologically advanced care NICU for the premature and critically ill infant will be completed by December 2015.

Located in Honolulu County, KMCWC provides services, to the rest of the State including Kaiser and Tripler Army Medical Center (TAMC), for infants requiring specialized procedures not available at the respective facilities. Kaiser Medical Center - which provides services only to subscribers of its health plan, and TAMC that provides obstetrical care for the military population on the island of Oahu as well as referral for care for military and civilian patients from the Pacific island and Asia, both report a Level III NICU. TAMC has a 16 bed NICU which admits approximately 300 infants annually.

The KMCWC Neonatal Transport Program is responsible for managing the transport of infants from other hospitals on Oahu and on other islands, as well as from Hawaii to the Mainland. Specially trained transport nurses and respiratory therapists accompanied by a neonatologist or fellow for critically ill infants are on each team and work collaboratively with the air ambulance service.

The Hawaii Air Ambulance came under new management in 2006 and combined services with AirMed Hawaii with services renamed, Hawaii Life Flight. Hawaii Life Flight provides air ambulance medical transport from all neighbor island hospitals to Oahu, including obstetrical emergencies requiring a Level III NICU. There is an air ambulance and medical crew based strategically across the State to transport medical emergencies within 20 minutes of a call. The air ambulance bases are located in Hilo, Waimea and Kona of the Big Island, Lihue, Kauai, and Kahului, Maui. The Maui base serves Molokai and Lanai as well. The main base for Hawaii Life Flight is on Oahu, which can dispatch extra services to the neighbor islands and from rural areas of Oahu as needed.

Title V staff continued to administer the Perinatal Support Service (PSS) purchase of service contracts to provide case-management, care coordination and health education to high-risk pregnant women statewide. PSS Providers continued to screen for alcohol, tobacco and other drug use and provided brief intervention, and motivational interviewing to encourage abstinence. In this time period PSS data reported 1,257 live births and 12 very low birth weight (VLBW) infants were born. This is an improvement from the previous year in the same time period; with PSS data reports showing 1,097 live births and 20 infants born VLBW.

Funding for the Baby Substance Abuse Free Environment (S.A.F.E.) Programs for substance using pregnant women outreach, screening and referral ended on July 1, 2009 due to budget cuts.

The Healthy Mothers Healthy Babies (HMHB) Coalition of Hawaii continued to administer the Title V funded pregnancy information and referral hotline and website.

In the 2009 Legislative Session, House Concurrent Resolution (HCR) No. 215, "Requesting the Department of Health to Review and Assess the Policies and Procedures Implemented by Hospitals to Reduce Elective Cesarean Sections and Induction of Labor," was assigned to Title V staff to report on. An initial workgroup with DOH, March of Dimes and HMHB representatives was convened to establish a plan of action and timeline to report back to legislators. Very low birth weight infants are often the result of an elective cesarean section or induction of labor less than 39 weeks gestation.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Collect, analyze, and disseminate Hawaii data from the Pregnancy Risk Assessment Monitoring Survey (PRAMS).			X	X
2. Execute and administer contracts for perinatal support services to assure access to services for high-risk pregnant women statewide.	X	X		X
3. Administer the federal HRSA grant for the Big Island Perinatal Disparities program to provide outreach and support services for high-risk pregnant women to assure access to care and reduce poor birth outcomes like low birth weight.	X	X		X
4. Execute and administer contracts to enhance the statewide perinatal system of care through assessment and advocacy; pregnancy resource referral and information (phone line and website); and perinatal provider education and training.		X	X	X
5. Assure access from the neighbor islands to tertiary care centers through the air ambulance system.				X
6. Support efforts to improve coordination and collaboration among perinatal providers.				X
7. Promote partnerships to assess, address and improve upon policies and practices which can positively impact perinatal, prenatal health services and high risk deliveries.				X
8.				
9.				
10.				

b. Current Activities

Due to the State budget cuts, funding allocation for the PSS Program was reduced and contracts modified. The PSS Program in the rural North Shore on Oahu was discontinued, and the island of Lanai contract is now with the Lanai Community Health Center. PSS Providers continue activities towards program goals to reduce preterm births and VLBW infants.

The Text4baby campaign for Hawaii is in development by HMHB Coalition of Hawaii. Text4baby, a program of the National HMHB, uses mobile technology, a free service designed to promote maternal and child health educational messages. Women sign up for the service and receive weekly text messages timed to their due date.

Title V staff continue to convene a workgroup to develop a report on HCR 215. A survey was conducted to gather information on State hospital policies and practices regarding cesarean deliveries and induced labor. Addressing this issue could potentially reduce the rate of infants born VLBW.

The Prenatal Smoking Workgroup was established as result of the 2005 Title V needs assessment to convene key public and private smoking prevention and perinatal stakeholders to share information and collaborate on policy and program planning. The group met quarterly, co-chaired by Title V staff and an Ob-Gyn who is part of the DOH advisory team administering the Tobacco Trust Fund. Recent Workgroup meetings have focused on assessing the availability of tobacco cessation resources due to the State budget reductions.

c. Plan for the Coming Year

Objectives for this measure were set to achieve the HP 2010 objective of 90% in 2010. Provisional data for 2009 will be updated.

The continuation of support services to high-risk pregnant women will be based on future funding allocations which are uncertain at this time. A request for proposals to purchase perinatal support services will be conducted by November 2010. Discussions with current PSS Providers and other perinatal providers will occur in the development of new contract goals and program planning to prioritize community needs in accordance with the availability of funds. Goals to reduce the incidence of VLBW infants will continue.

The Prenatal Smoking Workgroup will continue to assess smoking cessation resources targeting pregnant women to reduce the incident of LBW babies. The Workgroup continues to share information on smoking cessation efforts by perinatal providers and consider policy options to increase services for smoking cessation and prevention efforts targeted to pregnant women and women of reproductive age. Legislation requesting Medicaid reimbursement for smoking cessation counseling has been discussed, but the economic climate prohibits serious consideration at this time. There are over a hundred people statewide certified to train on smoking cessation counseling and efforts to train more medical providers will continue.

DOH Healthy Hawaii Initiative (HHI), chronic disease prevention program, was awarded a CDC ARRA-funded Communities Putting Prevention to Work State Initiative program to expand promotion efforts for the State Tobacco Quitline.

The HMHB Coalition of Hawaii has plans to promote Text4baby extensively throughout the State to provide health messages via the free text messaging system. The HMHB will continue to administer the Title V funded pregnancy information and referral hotline and website.

The federal Healthy Start Big Island Perinatal Health Disparities Project (BIPHDP) will continue to provide services to improve birth outcomes and reduce VLBW for high-risk Hawaiian, Pacific Islanders, Hispanic, Filipino pregnant women and all adolescents in Hawaii county. The BIPHDP will be in the second year of a five year grant cycle.

The Title V staff will continue to assess the outcome of the HCR 215 legislative report and monitor policies and practices of birthing hospitals for elective cesarean section deliveries and induction of labor.

The Hawaii Pregnancy Risk Assessment Monitoring Survey (PRAMS) will continue to provide data on pregnancy risk behaviors such as smoking, drinking and depression which relate to VLBW. PRAMS will be a data source for six Healthy People 2020 objectives and the Centers for Disease Control and Prevention will revise survey questions in 2012. In this process Hawaii

PRAMS will evaluate core and State questions on some topics. Questions related to factors impacting VLBW are critical and will remain as a key component of this surveillance system.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	81	82	83	84	85
Annual Indicator	79.1	79.0	77.9	79.9	78.8
Numerator	14151	14957	14868	15514	14849
Denominator	17882	18927	19086	19408	18836
Data Source				Hawai'i State Vital records	Hawai'i State Vital records
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	86	86	86	86	86

Notes - 2009
Data is for resident population and is by calendar year. Data for the year 2008 was revised with an updated birth data file. Data for the year 2009 is based on a provisional birth data file.

Notes - 2007
Data is for resident population and is by calendar year. Data for the year 2006 was revised with an updated birth data file. Data for the year 2007 is based on a provisional birth data file.

a. Last Year's Accomplishments
Provisional data for 2009 indicates 78.8% of pregnant women received first trimester prenatal care (PNC). The State objective of 85% was not met nor did Hawaii meet the Healthy People 2010 objective of 90%.

Title V staff provide overall management and administration of Perinatal Health Programs and the Pregnancy Risk Assessment Monitoring System (PRAMS). The Perinatal Support Services Program (PSS) provides services for high-risk pregnant women at 9 sites throughout the State serving approximately 3,000 women annually. The programs are required to track client service utilization, and prenatal care initiation. According to the PSS database, 59% of PSS clients were seen for PNC in the first trimester.

In September 2009, PSS contract providers received training on using contract performance measures to evaluate and improve program quality. PSS providers are encouraged to identify program activities to improve performance measure rates including the percentage of clients entering prenatal care in the first trimester. PSS providers also perform community outreach and hold community health fairs to promote awareness of the importance for early prenatal care.

On July 1, 2009 funding for PSS was decreased and the Baby Substance Abuse Free Environment (S.A.F.E.) program budget was eliminated due to State budget cuts. Baby S.A.F.E. program activities included outreach to substance using pregnant women, to encourage early and continuous prenatal care with an emphasis on alcohol, tobacco and drug abstinence support and counseling during pregnancy. The need to outreach and provide services to substance-using pregnant women now rests with the remaining PSS providers who are already struggling with maintaining services with less funding. It may be challenging for perinatal health programs to sustain service outcomes like providing timely PNC under these circumstances.

Federal funding continues to support the Healthy Start Big Island Perinatal Disparities program (BIPDP) services to high-risk pregnant women on the island of Hawaii. Target populations for BIPDP are the Native Hawaiians, other Pacific Islanders, Hispanics and adolescents, these populations tend to seek late prenatal care. As an incentive, the contract provider receives a higher reimbursement rate for pregnant women enrolling in the first trimester of pregnancy.

The Healthy Mothers Healthy Babies (HMHB) Coalition of Hawaii helps to improve the perinatal system of care by conducting statewide perinatal needs assessment, coordinating activities and communication between organizations and keeping stakeholders informed of perinatal legislation. HMHB also manages the pregnancy resource, referral, information phoneline and website. The phoneline and website can assist pregnant women with Medicaid insurance to find an OB/GYN and to facilitate early PNC. HMHB also monitors the Medicaid application process for pregnant women to address unnecessary delays for early PNC.

HMHB reports that the neighbor islands continue to lack adequate numbers of OB/GYN and other perinatal specialty care providers which reduces access for early PNC. With families losing health insurance due to job losses, a result of the poor economy, early PNC rates may be affected.

The Perinatal Addiction Treatment of Hawaii (PATH) clinic for substance-using pregnant women continued to provide comprehensive perinatal clinical and social services to women with a history of substance abuse despite funding shortfalls. The PATH program director was successful in securing continued funding to sustain services in fiscal year 2010.

The Kalihi-Palama Health Center (KPHC) on Oahu continues prenatal groups to encourage ongoing PNC. KPHC utilizes the Centering Pregnancy method with one group for Chuukese women and another group for English speaking women. KPHC reports that immigrant pregnant women prefer this prenatal care approach and are more likely to keep prenatal appointments within a group of women with similar cultural background.

The Hawaii PRAMS database is updated every year and provides trend data on pregnancy behaviors. PRAMS data on PNC found that women who were less likely to obtain early care were Hispanic, Hawaiian, Samoan, or other Pacific Islander, younger in age, less educated, unmarried, and had Medicaid/QUEST insurance or was uninsured.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Facilitate ongoing assessment of access into prenatal care through use of vital statistics, PRAMS, Perinatal Support Service programs, federal Healthy Start Perinatal Disparities Project program data.				X
2. Execute and administer contracts for perinatal support services to high-risk pregnant women statewide to promote the	X	X		X

importance of entry into first trimester and ongoing prenatal care.				
3. Administer the federal Healthy Start grant for the Big Island Perinatal Disparities program to provide outreach and support services for high risk pregnant women including a focus on entry into first trimester pregnancy and ongoing prenatal care.	X	X		
4. Provide culturally competent service delivery through a variety of sources in areas with populations of higher risk women to improve outcomes related to infant mortality and morbidity.		X		X
5. Execute and administer contracts to enhance the statewide perinatal system of care through assessment and advocacy; pregnancy resource referral and information (phone line and website); and perinatal provider education and training.		X	X	X
6. Facilitate community engagement by supporting the formation of local organizations (consortiums) to increase access to first trimester perinatal care and improve system-wide service delivery.		X		X
7. Continue state perinatal partnerships for assessment and advocacy in improving first trimester prenatal care access issues.				X
8.				
9.				
10.				

b. Current Activities

PSS providers, particularly at community health centers, continue to facilitate early prenatal care by assisting uninsured pregnant women with Medicaid applications and continue to perform community outreach to promote awareness on the importance of early prenatal care.

The federal Healthy Start BIPDP employs Neighborhood Women for outreach to targeted at-risk populations to improve access to first trimester prenatal care. Local area consortiums also work on improving service delivery and implement action plans to increase access to care.

The PATH Clinic continues to provide services for pregnant women with substance abuse problems but the program is seeking program funding to continue services through the next year.

The KPHC continues to conduct the Centering Pregnancy prenatal care groups. The groups, conducted in Chuukese and English, are comprised of 8-12 pregnant women that share similar delivery dates. Groups meet for 90 minutes each month starting at approximately 12 weeks of pregnancy. The first prenatal visit is with the OB/GYN or nurse midwife before assigning women to a group that provides encouragement for continuous prenatal care.

HMHB continues the Pregnancy Warmline with a toll-free phone number for neighbor island calls and a website for online access to pregnancy resources and information. HMHB reports that many women call requesting assistance to locate prenatal care providers that accept Medicaid insurance.

c. Plan for the Coming Year

The performance measure objectives will be reassessed next year based on an review of the past 5 years of data and the new Healthy People 2020 objective. Provisional 2009 data will be updated next year.

The PSS contracts will end in June 2011 and new purchase of service (POS) contracts will be developed for the next biennium. Program services and performance measures will include early

access to prenatal care. With the current State budget shortfall projected to last through 2011, the PSS Providers are in dialogue with the Title V agency to develop the next POS contract provisions anticipating further funding reductions. Changes will likely be made to support a more integrated approach for care to address the loss of services and to promote a holistic care approach to support improved health outcomes.

The limited perinatal resources on the Big Island makes early prenatal care a bigger challenge for pregnant women. The federal Healthy Start BIPDP plans to continue to target the Hawaiian, Pacific Islander, Hispanic and adolescent populations and provide assistance to enable access for early prenatal care.

The poor economy has impacted the state Medicaid agency with position eliminations through a state reduction in force and delayed payments to health care providers. Healthy Mothers Healthy Babies (HMHB) Coalition of Hawaii will continue to monitor the processing time for Medicaid applications for uninsured pregnant women and collaborate with Medicaid to minimize adverse impacts.

The HMHB Coalition of Hawaii plans to implement Text4baby, a national mobile health initiative on maternal and infant health. Women who sign up for the service by texting BABY to 511411(or BEBE for Spanish) will receive free text messages each week, timed to their due date or baby's date of birth. These messages focus on a variety of topics critical to maternal and child health: immunization, nutrition, seasonal flu, mental health, birth defects prevention, oral health, and safe sleep among others. Text4baby messages also connect women to early prenatal care as well as a variety of existing resources available to them.

A PRAMS 8-year trend report will be published in July 2010. Revision of the Hawaii PRAMS survey questions are likely to occur.

HMHB and Title V will begin to examine the affects of federal health care reform on access to PNC.

D. State Performance Measures

State Performance Measure 1: *The percent of pregnancies (live births, fetal deaths, abortions) that are unintended.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		48	47	46	45
Annual Indicator	52.4	52.3	52.9	47.9	47.9
Numerator	11329	12046	12108	11377	11377
Denominator	21636	23016	22880	23749	23749
Data Source				Hawai‘i State Vital records	Hawai‘i State Vital records
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	44	43	42	42	

Notes - 2009
Data for this measure comes from the Hawai'i Pregnancy Risk Assessment Monitoring System (PRAMS) and vital statistics. Data for the year 2008 is the latest data available from PRAMS, and estimates from vital statistics for fetal deaths and abortions are unreliable in provisional estimates available at time of this report so the 2008 vital statistic estimates are used.

PRAMS provides surveillance of unintendedness in pregnancies that resulted in a live birth. The percentage of unintended pregnancies derived from PRAMS is applied to the number of live births and fetal deaths to residents for the year. All abortions are also added to the numerator. The PRAMS rate alone underestimates unintendedness prevalence as it does not include those pregnancies that ended in abortion or fetal death. The denominator for this measure is all live resident births, fetal deaths, and abortions.

Notes - 2007
Data for this measure comes from the Hawai'i Pregnancy Risk Assessment Monitoring System (PRAMS). The Hawai'i State Department of Health started PRAMS in June 1999 as a pilot project. The year 2000 is the first full year of PRAMS data. Data for the year 2006 is the latest data available.

PRAMS provides surveillance of unintendedness in pregnancies that resulted in a live birth and is used with vital records in Hawaii (as well as several other states) to calculate this measure. The PRAMS rate alone underestimates unintendedness prevalence as it does not include those pregnancies that ended up as an abortion, which are very likely to have been an unintended pregnancy.

a. Last Year's Accomplishments
This measure reflects the State priority to reduce Hawaii's rate of unintended pregnancies. The 2008 data (last available) indicates 47.9% of pregnancies in the State were unintended. The objective was not met, nor was the Healthy People 2010 Objective of 30%. The unintended rates for this measure have been relatively stable over the past 5 years.

In 2009, approximately 48,750 women in Hawaii (under 250% of the Federal Poverty level for Hawaii) needed public supported contraceptives and services (Contraceptive Needs and Services, 2006; 2009, Guttmacher Institute). Hawaii PRAMS data reveal that 47.1% of pregnancies resulting in a live birth were unintended. 56.2% of women with an unintended pregnancy reported not using contraceptives. Given this data, a significant amount of unintended pregnancies may be prevented by using effective contraception, but it is not the only factor of prevention. Reasons for not using contraceptives among unintended pregnancies continue to be: didn't mind if they got pregnant, problems getting birth control, husband/partner not wanting to use contraception, side effects, and didn't think could get pregnant.

In 2008 the State Legislature appropriated $1,248,750 for family planning (FP) clinical and contraceptive services. $463,587 in Temporary Assistance to Needy Families (TANF) funds were also appropriated for expanded community health education and outreach services to increase awareness and utilization of clinical services. A memorandum of agreement between the Department of Human Services, the State TANF agency, and DOH was executed to permit the interdepartmental transfer of funding. FY 2009 restrictions resulted in $969,504 (clinical) and $407,956 (TANF) funding remaining from FY 2008 appropriations.

Prevention of unintended pregnancy continues by providing greater access to contraception through conveniently located, publicly supported FP services. Thirty-nine clinics on 6 islands provided services through the federal Title X program part of the Title V agency. Target populations are the uninsured and underinsured; men and women; adolescents; those with limited English proficiency; disparate groups such as homeless, substance users, and low-income individuals. The DOH is the only Title X grantee for Hawaii contracting with 11 community health centers, 4 community college health centers, and 3 community-based non profit organizations in

rural areas for subsidized FP clinical and health education (HE) services. There were also four private medical doctors who provided FP services but these agreements ended in December 2010 due to state fiscal restrictions.

In FY 2009, 22,137 clients were provided subsidized FP clinical services over 36,923 clinical visits; of these 9,575 were uninsured. Approximately 20% of visits (2,182 clients) were for a positive pregnancy test noted as an unplanned pregnancy.

FP contract providers offer clinical, educational, case management, outreach and referral services. Translation, interpretation services, and FP HE materials culturally tailored to meet the needs of various racial/ethnic, geographic, and disparate groups are also provided. FP service referrals continue for clients from other Title V programs.

The Male Achievement Network (MAN) Project through the Waikiki Health Center provides outreach and educational counseling services to males most likely to engage in risky sexual behaviors including incarcerated youth and those attending alternative schools for at-risk youth. In FY 2009 there were 3,040 direct male contacts; of these 70 received FP clinical services.

Population-based services were provided through Title X statewide FP community health educators. Activities included presentations, distribution of educational materials, and health fairs. In FY 2009 the FPP HE program made 70,753 direct contacts (through individual or group sessions) and 446,714 indirect contacts (health fairs, exhibits, media information). With the additional state FP funding, community health educators worked with the area FP clinics to improve access to services.

In FY 2009, FPP sponsored "Family Planning Challenges: Adolescent Brain/Human Trafficking" for FP providers and "Advanced Counseling" trainings for FP counselors. Ninety-nine FPP providers and reproductive health experts attended the 28th Annual Family Planning and Reproductive Health Conference which also promoted the 2009 Hawaii Women's Health Week.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Conduct the Pregnancy Risk Assessment Monitoring Survey (PRAMS) to provide data on unintended pregnancy for needs assessment and program planning.				X
2. Execute and administer family planning contract services to assure access to services for the uninsured, underinsured and other populations of women and males in need statewide.	X	X		X
3. Provide reproductive health education and community-based education contracts targeting at-risk populations.		X	X	X
4. Provide monitoring, technical assistance and training for Title X funded contractors				X
5. Provide reproductive health training and informational conferences for contractors and other providers.				X
6. Plan for Title V and Title X needs assessment to determine the progress made on unintended pregnancy and identify strategic areas where improvement is feasible.				X
7. Support Women’s Health activities including the promotion of the importance of preventive screening and check-ups.			X	X
8.				
9.				
10.				

b. Current Activities
FPP services continue despite elimination of FP TANF funds for community-based FP health education for FY 2010. In FY 2010, with general fund restrictions only $969,505 remained for clinical services. The FP HE service contracts were modified with budget cuts and most became 50% time providers with lower service delivery requirements. It is projected in FY 2010 only 30,000 direct individual and group session contacts and 237,500 indirect contacts (fairs, exhibits, media information) will be made due to budget cuts.

In September 2009, $60,000 in supplemental Title X funds was received for FP clinical provider training and FDA-approved reversible contraception (i.e. Implanon and intrauterine, IUD) devices. Fifteen contracts were modified to add training and supply funding. Two Implanon trainings were offered and 16 FP providers statewide were certified resulting in service availability for Kauai and Lanai FP sites. By June 30, 2010 it is anticipated an additional 130 clients will receive hormonal implants or IUDs.

The Title V Women's Health Program continues to coordinate the Women's Health Week Committee of community partners disseminating preventive health care and screening guide information (including reproductive health) for women. Approximately fifty-three thousand culturally tailored guides were distributed in local stores, libraries, health centers, and health fairs. Health promotion messages were placed on bus placards and government pay stubs during Women's Health W

c. Plan for the Coming Year
It is uncertain at this time what the state funding restrictions may be based on the economic situation but it is anticipated there will be a further reduction in funds.

FPP will continue to monitor contracts, offer training and technical support to contract providers to assist uninsured and underinsured populations to obtain family planning reproductive health information and access to effective contraception to prevent an unintended pregnancy. In FY 2010 there will be 35 FP providers often located in underserved geographical areas statewide.

A provider IUC insertion practicum will be offered at the 2010 Annual Family Planning Reproductive Health Conference and is anticipated to support provider skills and increase access to this effective contraceptive method.

The 2009 Hawaii Youth Risk Behavior Survey shows an increase from 2007 in public high school students reporting ever having sexual intercourse (44.3% vs. 36.2%), sexual intercourse prior to age 13 (6.0% vs. 5.1%), sexual intercourse with four or more persons during their life (11.1% vs. 6.1%), sexual intercourse with at least one person during the 3 months before the survey (23.6% vs. 30.5%) and for those currently sexually active who drank alcohol or used drugs before last sexual intercourse (30.2% vs. 27.2%). To address these outcomes, the FP community-based health education program will continue to collaborate with agency and community-based groups to educate people on reproductive health including risky sexual behavior, benefits of abstinence and delaying sexual intercourse, contraception options, and consistent condom use in prevention of STDs.

The FP HE Program is also working on adapting an existing evidence-based, standardized reproductive health curriculum in collaboration with the FP contract providers and the Department of Education to be used in schools and in the community by FP health educators. This school curriculum will be brief, yet comprehensive, and offer pre and post tests for the health educators to measure effective outcomes such as increased knowledge in sexual health during school or community presentations.

The MAN Project targeting homeless male youth will continue through February 2010 to allow

time to implement and test key evaluation recommendations, support development of lesson plans which can be used for male services statewide and promote healthy reproductive decisions and use of contraception to high risk men.

The Women's Health Section and its FPP program has begun to review in more depth State and program data including ethnicity, age, pregnant women and those wanting to become pregnant, primary contraceptive method, insurance and income level. Next steps are anticipated to include surveying (client, focus groups, and key informant interviews) to assess factors impacting specific groups in the area of unintended pregnancy and contraceptive use, unique cultural beliefs, and problems faced by various Hawaii population groups.

State Performance Measure 2: *Percent of infants with hearing loss who are receiving appropriate intervention services by age 6 months.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		70	70	72	74
Annual Indicator	71.4	58.1	78.9	54.3	67.3
Numerator	50	36	45	38	37
Denominator	70	62	57	70	55
Data Source				Hawai'i State Vital records	Hawai'i State Vital records
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	76	78	80	80	

Notes - 2009
For 2002-2004, the denominator is the number of infants with permanent hearing loss who did not pass the newborn screen. Beginning in 2005, the denominator is the number of infants with permanent hearing loss who did not pass the newborn screen minus infants who died or moved out of state after diagnosis, as reported to the state Newborn Hearing Screening Program for use in annual calendar year reports to the Centers for Disease Control and Prevention. The numerator is the number of diagnosed infants referred for Early Intervention services by 6 months of age. Data is reported by calendar year. Data for 2007 and 2008 was updated. Data for 2009 is preliminary.

Notes - 2007
For 2002-2004, the denominator is the number of infants with permanent hearing loss who did not pass the newborn screen. Beginning in 2005, the denominator is the number of infants with permanent hearing loss who did not pass the newborn screen minus infants who died or moved out of state after diagnosis, as reported to the state EHDI program for use in annual calendar year (CY) reports to the Centers for Disease Control and Prevention. The numerator is the number of diagnosed infants referred for Early Intervention services by 6 months of age. Data for CY 2005 and 2006 (Jan-Dec) were updated. Data for CY 2007 (Jan-Dec) are preliminary.

a. Last Year's Accomplishments
Preliminary 2009 data indicated 67.3% of children with confirmed hearing loss received intervention service by age 6 months. The objective was not met. The 2009 data will be updated next year.

The 2008 final dataset showed that of the 71 infants diagnosed with permanent hearing loss, 1

family moved to the mainland, 4 parents refused early intervention (EI) services, 38 infants received EI services before age 6 months, 19 received EI services after age 6 months, and 8 were lost to follow-up/documentation (LFU/D). Factors contributing to the low rate of follow-up are: staff shortage for the Newborn Hearing Screening Program (NHSP), the lack of information about EI enrollment and services; and enrollment into EI services after age 6 months.

NHSP was established in 1990 by statute, mandating the DOH develop a statewide program for screening of infants/children age 0-3 years for hearing loss. Screening began in 1992 and is now part of standard newborn care in Hawaii. Amendment of the law in 2001 mandated screening all newborns for hearing loss and reporting screening results to the DOH. Hearing screening is now available to families statewide, regardless of birth location.

NHSP works with hospitals, physicians and other service providers to assist families with obtaining appropriate follow-up evaluations if their infant does not pass newborn hearing screening and with referral for Part C EI services if a permanent hearing loss is identified.

The DOH Early Intervention Section (EIS) provides EI services for children under age 3 years with special needs, including those with any type, degree, or laterality of permanent hearing loss. Families may contact EIS at any time before their child's third birthday to access services.

Other programs and persons may refer infants with hearing loss to EI, although NHSP is not informed of these referrals without parental consent. In 2008, all parents were asked to sign a consent form to share information with NHSP at the time of enrollment in EI services. The consent information will be entered into a new EI database system. The new system will improve data sharing between NHSP and EI to include more infants with hearing loss who are receiving EI services by age 6 months.

A Parent Coordinator at NHSP was hired to provide direct supports to parents. Parents who refused evaluation or EI services were contacted and additional information provided. Monthly parent support group meetings are also held.

The Early Hearing Detection and Intervention (EHDI) Advisory and the Newborn Screening Coordinators Committees met regularly to provide input on state program policies and procedures.

NHSP and EIS continued to collaborate with the "EHDI Champion" pediatrician representing the American Academy of Pediatrics-Hawaii Chapter. Areas included educational sessions for health care providers, policy development, and technical support to hospital screeners.

The EI Hearing Specialist position was vacant. A temporary part time provider was contracted to continue serving children with hearing loss and make home visits. Working relationships continued with the Gallaudet University Regional Center, Hawaii Deaf-Blind Project, Hawaii School for the Deaf/Blind, and Kapiolani Community College American Sign Language (ASL) Interpreter Program to share resources and to collaborate on training projects.

Ohana Time informational family support meetings were held. Participating families networked with other families to learn about community resources and follow up options if their child had confirmed or suspected hearing loss. The Deaf Mentor project continued to provide support to families to learn about Deaf culture, understand the needs of infants with hearing loss, and learn communication techniques to foster language development.

NHSP participated in the National Initiative for Children's Healthcare Quality's (NICHQ) Learning Collaborative B (LC-B) on newborn hearing screening. A LC-B state team with members from different disciplines was formed to serve as the advisory committee. The project focused on reducing loss to follow-up in screening, evaluation and intervention. Planned activities were tested at the participating pilot hospitals.

Funding from the federal MCH Bureau Baby Hearing Evaluation and Access to Resources and Supports (Baby HEARS) program supports NHSP efforts to improve newborn hearing screening and follow-up.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaborate with screening sites to ensure timely referral of infants who need evaluation.		X		X
2. Inform families of infants w/ hearing loss about audiological evaluation and early intervention.	X	X		
3. Assist families in arranging needed audiological evaluations and transportation support.	X	X		
4. At family request, refer infants with confirmed hearing loss for early intervention services.		X		
5. Provide consultation to early intervention staff on treatment planning for infants with hearing loss and on family support.		X		X
6. Expand lending libraries with videos and other materials on management and other aspects of hearing loss.		X		X
7. Collaborate with other community deaf education services for families of infants with hearing loss.		X		X
8. Provide education, workshops, and training to improve understanding of hearing loss and early intervention/other services.				X
9. Monitor/track audiological evaluations results, hearing, amplification, and early intervention enrollment.		X		X
10.				

b. Current Activities

NHSP is improving its tracking and follow-up/coordination services for infants who fail inpatient or outpatient hearing screening. NHSP is strengthening supports to hospitals and other providers to meet the EHDI recommended "1-3-6" timeline: screen all infants by 1 month, evaluate by 3 months, and refer children with hearing loss (H/L) to EI by 6 months. Parent-to-parent support is provided to families with children who are referred for follow-up and to families of children with confirmed H/L. Collaboration with the medical home is improving. NHSP continues to participate in the NICHQ LC-B to reduce the loss of families to follow-up.

NHSP and EIS provide information about hearing, speech and language development to families of infants referred for EI. Educational brochures were sent to EI programs in 12 languages and are available on the NHSP website. The Hawaii Resource Guide for Families of Children with Hearing Loss has been reprinted and is available to EI programs and audiologists.

EIS provides services such as audiological evaluations and hearing aid related services for infants with permanent H/L. EIS has a procedure to support purchase of hearing aids with state funds upon family request. Children with Special Health Needs Program (CSHNP) also assists income-eligible families with purchase of hearing aids. EIS and CSHNP maintain a hearing aid and FM system loaner bank. Ohana Time, the Deaf Mentor project, and Family Signing classes continue.

c. Plan for the Coming Year

NHSP will continue to refer infants with permanent H/L for EI services, and will monitor and track diagnostic audiological evaluations, confirmed hearing status, amplification, and EI enrollment status. Electronic matching will be established between NHSP and EI to facilitate follow-up when the EI database system is finalized.

EIS will continue to provide EI services for infants with permanent H/L, including audiological evaluations, hearing aid related services, and transportation support. CSHNP and EIS will continue to assist income-eligible families with the purchase of hearing aids for infants with permanent H/L.

NHSP and EIS will continue providing information about hearing, speech and language development to families of infants referred for EI. Educational brochures and the Hawaii Resource Guide for Families will be disseminated. Education for health care providers will continue.

The EI Hearing Specialist and contracted Deaf Educators will provide consultation and services for children under age 3 years with H/L and their families, and for EI staff. The Deaf Mentor project and Family Signing classes will continue. The Family Signing classes are offered to parents by the HI School of Deaf/Blind. EI covers tuition cost for EI parents. Collaboration with Hawaii School for the Deaf/ Blind, Gallaudet University Regional Center, and Hawaii Deaf-Blind Project will continue.

The activities piloted in the NICHQ LC-B project on newborn hearing screening will be implemented statewide. These activities include the Family Guide (roadmap) and other educational materials for families with infants who have confirmed or suspected H/L, and the "Stork Card", a hearing screening result report card for parents.

Lending libraries have been established in each EI program, consisting of resources and curriculum for serving children with hearing loss and their families. In 2010, the lending libraries will be expanded to include more sign language educational materials. The hearing aid and FM system loaner banks will also expand.

The EHDI Advisory Committee, the Providers Committee and the Newborn Screening Coordinators Committees will continue to meet and provide input on state program policies and procedures.

The NHSP Parent Coordinator will continue to provide support for families of children with H/L at the diagnostic and intervention stages of the EHDI process and to facilitate statewide family support activities. Ohana Time informational family support meetings will continue.

NHSP will continue its Baby HEARS project activities that include improving follow-up coordination, roadmap to inform families about the follow-up process, updating hospital screening equipment, establishing community screening sites, and improving access to diagnostic services on rural islands. The HI*TRACK newborn hearing screening database program will be upgraded to facilitate data transfer from screening hospitals and for better tracking of follow-up needs.

State Performance Measure 3: *The percent of teenagers in grades 9 to 12 attending public schools who are overweight.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		13	12	12	11
Annual Indicator	13.5	13.5	15.6	15.6	14.5

Numerator					
Denominator					
Data Source				Hawai‘i State Vital records	Hawai‘i State Vital records
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	11	11	11	11	

Notes - 2009
The data comes from the Hawaii Youth Risk Behavior Survey (YRBS). YRBS is administered in odd-numbered years in Hawai‘i’s public middle and high schools. The extent of underreporting or over reporting of behaviors cannot be determined because information is self-reported. The data apply only to youth who attend Hawai‘i’s public schools and, therefore, are not representative of all persons in this age group. The survey is conducted every two years.

Notes - 2008
The Hawai‘i Youth Behavior Risk Survey (YRBS) for Middle School is data weighted to the general population by the Centers for Disease Control and Prevention (CDC). YRBS is administered in odd-numbered years in Hawai'i's public middle and high schools. The extent of underreporting or over reporting of behaviors cannot be determined because information is self-reported. The data apply only to youth who attend Hawai'i's public schools and, therefore, are not representative of all persons in this age group.

Notes - 2007
The data comes from the Hawai‘i Youth Risk behavior Survey (YRBS). YRBS is administered in odd-numbered years in Hawai'i's public middle and high schools. The extent of underreporting or over reporting of behaviors cannot be determined because information is self-reported. The data apply only to youth who attend Hawai'i's public schools and, therefore, are not representative of all persons in this age group. The survey is conducted every two years.

a. Last Year's Accomplishments
This measure reflects the State priority to reduce rates of child/adolescent overweight. The 2009 Youth Risk Behavior Survey (YRBS) data showed 14.5% of high school youth were obese according to Body Mass Index (BMI) charts, a slight decrease from the 2007rate (however, the difference between the rates was not statistically significant). Hawaii's rate of 14.5% was higher than the national rate (13.0%) but not significantly. The state objective was not met; nor was the Healthy People 2010 objective (5%).

Healthy Hawaii Initiative (HHI) continues to be the department lead to promote healthy lifestyles such as increased consumption of fresh fruits and vegetables, increased physical activity and prevention of smoking and use of tobacco products and promotion of tobacco cessation efforts. They continue to developed tools, training sessions, and networking opportunities for agencies and community members across the islands to increase understanding on how the physical design of the built environment impacts opportunities for daily physical activities.

In 2009, a Safe Routes to School Bill (Act 100) was passed to support the Department of Transportation (DOT) to implement the provisions of federal legislation. Also passed was a Complete Streets Bill (Act 54) directing the DOT and county transportation agencies to adopt a complete streets policy to reasonably accommodate access and mobility for all users including pedestrians, bicyclists, disabled, the elderly and children. DOH Injury Prevention and Control Program (IPCP) closely monitored the legislation and kept stakeholders apprised of these and other bills to improve street safety. These efforts support the overall efforts to promote healthy and safe walkable communities that support increased physical activity.

As part of the Title V Needs Assessment, child obesity was identified as a continuing state priority

issue. Stakeholder input was collected from a survey conducted in 2009. Title V's medical director continues to be instrumental in carrying on the work of the Pediatric Foundation of Hawaii and the Hawaii Chapter of the American Academy of Pediatrics, with the development of the "The Hawaii Pediatric Weight Management Toolkit" in 2007. A local pediatrician and dietician developed the toolkit to help providers implement recent national expert recommendations concerning evaluation and treatment of overweight children and adolescents. Title V sponsored training sessions on the Toolkit for primary care health center, other healthcare providers, Early Periodic Screening Diagnosis and Treatment (EPSDT) coordinators and Maternal Child Health Branch (MCHB) neighbor island coordinators. The toolkit includes worksheets to assess a child's medical history, activity and nutrition; behavioral tip sheets to review with a parent and child; and pages that parents are asked to fill out with information about the child. The toolkit continues to be used by pediatricians, dieticians, WIC staff and public health nurses statewide.

Hawaii has adopted a "Hawaii Physical Activity and Nutrition (PAN) Plan. HHI funds staffing for a state Nutrition and Physical Activity Coalition (NPAC) and neighbor island coalitions to implement the goals and objectives of the PAN plan. NPAC engages in infrastructure building, advocating systems changes, supporting legislation, and coordinating community efforts according to the PAN goals. State subcommittees include: school health, workforce, built environment, health system and nutrition. Title V staff participate in the state and neighbor island coalitions.

HHI implemented the USDA Food Stamp Nutrition Education Network program in Hawaii. The federal reimbursement program provided expanded funding to programs providing nutrition education to those individuals eligible for Food Stamp benefits. The Department of Human Services, which administers the Food Stamp program, contracted with HHI and the University of Hawaii's College of Tropical Agriculture and Human Resources to coordinate an integrated approach to nutrition education in schools and community health centers.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide training and support to Department of Education school teams to implement State Wellness Guidelines that include standards for food sold or provided on campus, nutrition education, physical education and activity, and staff development.				X
2. Assure data is available on youth weight and weight related behaviors through the Youth Risk Behavior Survey.				X
3. Promote the use of the Hawaii Pediatric Weight Management Toolkit among pediatric providers.				X
4. Implement the USDA Food Stamp Nutrition Education Network program to secure additional federal funding for programs providing nutrition education to individuals eligible for Food Stamp benefits.				X
5. Support community based organizations to plan and conduct health promotion activities and projects.				X
6. Promote healthy lifestyles through public education campaigns.			X	
7. Implement the State Physical Activity and Nutrition (PAN) Plan through the statewide network of NPAC coalitions.				X
8. Support Department of Health and community efforts to modify Hawai‘i’s built environment to promote safe and enjoyable physical activity through policy development, education, providing technical assistance, and community grants.				X

9. Work with state and county transportation planning agencies to support the development of pedestrian and bicycle-friendly communities including implementing the Safe Routes to Schools program.				X
10. Provide education and support on appropriate dietary practices and physical activity through the WIC program.		X		

b. Current Activities
State objectives are set to decrease 1% point every 2 years.

To assure continued surveillance, the DOH/DOE School Health Survey Committee (SHSC) is gearing up for YRBS which will be administered in the fall of school year 2011. The SHSC continues to work collaboratively on the school-level, health-related indicators, coordinate the school survey administration, and develop summary reports including the levels of physical activity, weight and nutrition data.

The WIC food voucher program which added fresh fruits and vegetables and whole grain bread to their food package for clients began on October 1, 2009 as a part of a national WIC initiative to create healthier options for its low-income client population.

HHI continues to partner with state/county agencies and community advocates to implement and support policy changes and programmatic activities to create healthier community design and transportation options.

DOT and the City and County of Honolulu (CCH) continues to update their bicycle plans to include bicycle accommodations for future rail transit stops. DOH will continue to partner with community advocates to work with transportation officials ensure the plans help to promote and increase safe physical activity options into community design and transportation systems.

The DOE in partnership with HHI will implement the Wellness Guidelines that includes standards for food sold or provided on campus, nutrition education, and physical education. Policies include a p

c. Plan for the Coming Year
Statewide, the Mental Health Transformation State Incentive Grant will begin to focus on a new messaging campaign: "Mentally Healthy, Physically Fit". There will be efforts to promote this message and implement supportive campaigns around this message

The DOH-DOE Wellness team will continue providing professional development and assistance on the multiple components of the Wellness Guidelines. Utilization of an online support to the Wellness Guideline toolkit school wellness' committees will be encouraged. The agreement between the Board of Education (BOE), the DOE and the DOH calls for all but two components to be in place by the end of the 2011 school year.

The "Let's Move Hawaii!" 2010 campaign is being launched in response to President and Mrs. Obama's national "Let's Move" campaign. The Hawaii Initiative for Childhood Obesity Research and Education (HICORE) affiliated with the John A. Burns School of Medicine (JABSOM) at UH Manoa is leading a multi-disciplinary, collaborative effort in childhood obesity research and education with the Hawaii NPAC leading the statewide effort. NPAC represents communities across the islands advocating policies and initiatives that optimize good nutrition and physical activity. The initiative is being funded by the HMSA Foundation.

The Hawaii Department of Health received $3.4 Million in American Recovery and Reinvestment Act of 2009 grants (ARRA) to emphasize policy and environmental change at both the state and local levels. The stimulus grants will go to Maui and Kauai to increase levels of physical activity;

improve nutrition; decrease obesity rates and increase residents' awareness and knowledge of healthy eating and active living through multiple media venues. Other activities will be to improve nutrition through social support, culturally appropriate education, and behavior change; increase access to and consumption of local produce including links to restaurants and grocery stores; restrict the availability of unhealthy foods in schools; promote healthy foods in grocery stores; and improve active transport and public transportation infrastructure.

The HOʻALA Project aims to help 12 Hawaii island schools reduce childhood obesity by improving the ability for children to get to and from school by walking or bicycling. Hawaiʻi is one of only eight locations in the U.S. to receive the "rapid response funding award" from the Robert Wood Johnson Foundation, through the Active Living Research Program.

HHI plans to continue efforts to promote healthy food choices and life-long physical activity on a statewide basis. Title V staff will continue to participate in county NPAC meetings and support HHI in the development of community-based resources, training, and capacity building opportunities.

State Performance Measure 4: *Percent of teenagers in grades 6 to 8 attending public schools who report drinking alcohol within the past 30 days.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		12	11	11	10
Annual Indicator	12.3	12.3	14.5	14.5	15.3
Numerator					
Denominator					
Data Source				Hawaiʻi State Vital records	Hawaiʻi State Vital records
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	10	10	10	10	

Notes - 2009
The Hawaii Youth Behavior Risk Survey (YRBS) for Middle School is data weighted to the general population by the Centers for Disease Control and Prevention (CDC). YRBS is administered in odd-numbered years in Hawaii's public middle and high schools. The extent of underreporting or over reporting of behaviors cannot be determined because information is self-reported. The data apply only to youth who attend Hawaii's public schools and, therefore, are not representative of all persons in this age group.

Notes - 2008
The Hawaiʻi Youth Behavior Risk Survey (YRBS) for Middle School is data weighted to the general population by the Centers for Disease Control and Prevention (CDC). YRBS is administered in odd-numbered years in Hawai'i's public middle and high schools. The extent of underreporting or over reporting of behaviors cannot be determined because information is self-reported. The data apply only to youth who attend Hawai'i's public schools and, therefore, are not representative of all persons in this age group.

Notes - 2007
The Hawaiʻi Youth Behavior Risk Survey (YRBS) for Middle School is data weighted to the general population by the Centers for Disease Control and Prevention (CDC). YRBS is

administered in odd-numbered years in Hawai'i's public middle and high schools. The extent of underreporting or over reporting of behaviors cannot be determined because information is self-reported. The data apply only to youth who attend Hawai'i's public schools and, therefore, are not representative of all persons in this age group. There will be no data for 2007 since it uses YRBS middle school data. Middle school data has not been published.

a. Last Year's Accomplishments

This measure reflects the State's MCH priority to reduce underage drinking. The 2009 Youth Risk Behavior Survey (YRBS) middle school data showed a slight increase from 14.5 to 15.3% of middle school youth had at least one drink of alcohol in the last 30 days. The 2009 objective was not met. Hawaii rates remain higher than the Healthy People 2010 objective of 11%. Social acceptability and accessibility makes alcohol the drug of choice among teens.

In the Department of Health (DOH), the Alcohol and Drug Abuse Division (ADAD) is the lead agency for underage drinking (UD). ADAD provides funding to the Hawai'i National Guard for their counter-drug program which supports the efforts of the Hawaii Partnership to Prevent Underage Drinking (HPPUD) Coalition, established to coordinate statewide efforts to address underage drinking. The members of the partnership represent county, state, and federal agencies, non-profit organizations, private businesses, and community residents concerned with the health of Hawaii's youth. ADAD also provides Honolulu Police Department (HPD) funds to conduct enforcement activities such as county park sweeps and Sting operations. The current structure of HPPUD includes a Statewide Advisory Council, and four active county coalitions. Title V staff serves on the HPPUD providing YRBS data, health risk information related to UD, and the public health perspective on prevention/education efforts.

ADAD administers several federal grants that help to support UD activities including a SAMHSA State Incentive grant ($10.5 million over 5 years) and two Office of Juvenile Justice and Delinquency Prevention grants ($350,000 each).

DOH's Fetal Alcohol Spectrum Disorder (FASD) coordinator continued to offer and provide training opportunities and presentations at no cost to HPPUD coalitions on the debilitating lifetime effects of FASD that may result from prenatal alcohol use.

Adults continue to remain the primary alcohol source for underage youth. The Honolulu Police Department (HPD) conducts "sting" operations at smaller retail stores to stop adults from purchasing alcohol for underage drinkers. The Honolulu Liquor Commission (LC) also has ongoing investigations conducted in nightclubs and bars. In 2008 HPD and the LC provided training to military police to develop a similar sting program for military personnel. Age verification checks were also instituted at various military facilities and continue today.

The second annual HPPUD Conference was held in Kailua-Kona, to bring together the neighbor island HPPUD coalitions to discuss enforcement and prevention activities, improve communications and expand statewide reach opportunities.

The Coalition for a Drug Free Hawaii (CDFH) sponsored a high school UD conference in May 2009 in pursuit of baseline information from youth on the prevalence of underage drinking data. More than 80 youth participated in this event including teens from the neighbor islands who were supported by scholarships. Surprisingly, the youth participants reported they would like more low cost or no cost extra-curricular activities that continue over a longer duration rather than one time events.

During the 2008-09 school year, Mothers Against Drunk Driving (MADD) trained high school students to present alcohol prevention information to elementary school aged children. Plans for an islandwide HPPUD summer activity at the Waterpark were cancelled due to loss of key private sponsors due to the poor state economy.

HPD continued to take the lead on advocacy efforts to pursue legislation to strengthen UD laws and support prevention programs. The ignition interlock bill, HB 981, was passed in 2008. A task force was created to study the costs and impacts of the law which requires DUI offenders to install a device in their vehicles that would prevent the engine from starting if their blood alcohol level was above the legal limit. The implementation date has been delayed to 2010.

The Hawaii National Guard, LC, the DAG, and CDFH partnered on activities including public service announcements, joint presentations at the middle and high school campuses, and Teach-Ins, which use student athletes to speak to their peers.

The Lt. Governor's (LG) office and the National Guard provide leadership to coordinate and publicize statewide UD activities. SAMHSA sponsored 23 UD Town Hall meetings hosted by various communities.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Assure data is available on youth risk behaviors including alcohol use through the Youth Risk Behavior Survey and the Alcohol, Tobacco and Other Drugs Survey.				X
2. Develop collaborative partnerships with the statewide Hawaii Partnerships to Prevent Underage Drinking Coalition to initiate programs and advocate for policies to reduce underage drinking.			X	X
3. Support the Lt. Governor's initiatives and leadership on underage drinking.			X	X
4. Coordinate and contract for underage drinking enforcement and public awareness programs.				X
5. Conduct ongoing activities and programs to prevent underage drinking by organizations like Mother Against Drunk Driving (MADD).			X	X
6. Support the national Teach-Ins program and ongoing classroom presentations on prevention of underage drinking.			X	X
7. Educate the public on the risk factors, protective factors and evidenced based strategies to prevent and reduce underage drinking.			X	X
8. Implement the HPPUD's Strategic Plan that addresses goals and objectives to change prevailing social norm that condone underage drinking (UD) and reduce UD rates.				X
9.				
10.				

b. Current Activities

The HPPUD released its strategic plan that emphasizes the importance of collaboration among local agencies and organizations dedicated to changing social norms that prevent UD. HPPUD continues to build partnerships across agencies and disciplines around enforcement, education, and policy.

Ongoing HPPUD activities include: public service announcements; Teach-Ins by HPPUD's speaker's bureau; support for prevention programs to raise awareness about UD by the neighbor island coalitions, the military, the Coalition for a Drug Free Hawaii, the Liquor Commission and HPD. Education continues on the state's UD laws including the increase of penalties for UD and the social host liability law targeting adults that host activities serving alcohol to minors.

The 3rd annual HPPUD conference was held on Maui this year. The neighbor island HPPUD leadership shared their work to reduce UD and shared ideas to improve statewide coordination.

The University of Hawaii Alcohol Project was established to decrease the UD problem on campus and reduce harmful over-consumption of alcohol among undergraduates. The program has conducted targeted messaging campaigns, initiated a safe ride program, issued policy advisories, coordinated campus events, and assisted with curriculum integration and educating the campus about brief intervention services for students at risk.

Legislation was passed this year to address existing implementation details regarding the new state ignition interlock program.

c. Plan for the Coming Year

The State objective is to decrease by 1% the number of middle school youth who report current alcohol use every 2 years.

HPPUD will utilize the state strategic plan to change the prevailing social norm that condones underage drinking (UD) and to reduce UD rates. The coalition will conduct activities in each of the four goal areas as funding permits: 1) reduce UD by enforcing UD laws and regulations; 2) educate youth and adults on the serious consequences of UD; 3) support communication and collaboration among agencies and organizations involved in UD prevention; and 4) support policies that address UD.

HPPUD has been progressive in passing legislation to reduce UD in the past 5 years. State laws include increased penalties for drunk driving, prohibiting consumption of alcohol in addition to purchasing and possession of alcohol for individuals under age 21, suspension of driving privileges for persons who illegally purchase, possess or consume liquor, and a social host liability law that prohibits providing alcohol to minors. Discussion will continue on pursuing an increase of the state alcohol tax and apply revenues towards prevention efforts and other policy ideas.

Year round education and public awareness activities are expected to continue. This includes poster board messages in the public buses, statewide Teach-Ins on UD to elementary schools, health fairs at the community and university, positive messaging, public service announcements, and the community town hall meetings. The social networking "More Than You Think" campaign complete with the two websites for young people and a "more than you know" youth campaign is under development.

The military and HPD sting operations will continue. The LC will continue to monitor the bars and nightclubs for underage drinkers.

FHSD lost its state-fund FASD coordinator position due to the RIF of state government employees; however, was able to maintain this function utilizing another position. HHPUD will continue to include FASD information into UD presentations.

HPPUD will participate in the collection of data to assess the social norms, perceptions, beliefs and activities of alcohol use by young people under the legal drinking age of 21; track enforcement activities; and coordinate UD presentations as requested by schools and the general public.

The alcohol, tobacco, and other drug use (ATOD) survey scheduled for 2011 will not occur due to budget restrictions. Periodically, ADAD conducts the survey of students in both public and private schools to monitor trends. In its place, ADAD has inserted many of the questions into the next

YRBS.

HPPUD will continue efforts to improve information sharing between the Honolulu and the neighbor islands regarding activities and training/workshop opportunities.

State Performance Measure 5: *Proportion of children aged 6 to 8 years with dental caries experience in their primary and permanent teeth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		73.4	71.4	70.7	70
Annual Indicator	73.6	74.4	72.1	72.4	72.4
Numerator	4626	5183	4445	3674	3674
Denominator	6285	6967	6165	5075	5075
Data Source				Hawai'i State Vital records	Hawai'i State Vital records
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	69.3	68.6	67.9	67.2	

Notes - 2009
Data is from the Department of Health Dental Health Division (DHD) which conducts the child oral health surveillance program. Oral examinations are conducted by DHD dental hygienists in public elementary schools in accordance with accepted dental epidemiology standards. In November 2009 the DHD Dental Hygiene Brach was eliminated due to state budget cuts, thus ending school based oral health programs and child dental data collection. FY 2008 is the last complete year of data. The indicator for 2008 is used for 2009.

Notes - 2007
Data is from the Department of Health Dental Health Division (DHD) which conducts the child oral health surveillance program. Oral examinations are conducted by DHD dental hygienists in public elementary schools in accordance with accepted dental epidemiology standards. Objectives have been set to decrease 2% each year.

a. Last Year's Accomplishments
This measure was chosen through the Title V needs assessment process by stakeholders. It is also one of the Healthy People 2010 objectives: reduce the proportion of children with dental caries experience either in their primary or permanent teeth.

The Department of Health's (DOH) Dental Health Division (DHD) previously provided the data for this measure. The Division will no longer provide this data due to deep budget cuts and loss of staff.

Hawaii's children continue to have worst rates oral health in the nation despite relatively high dental insurance coverage partially due to the lack of public fluoridated water sources. Private and public stakeholders continue to work together to improve the oral health of children in Hawaii.

In 2009, the statewide Hawaiian Islands Oral Health Task Force (HIOHTF) continued to meet and worked closely with the Primary Care Providers in the community to build dental capacity in at-risk communities and promote the efforts of families to identify and utilize a dental home. Funding and dental insurance coverage remain a barrier and the Task Force (HIDHTF) will continue to

work on building capacity in this area.

The Tri-County Oral Health Task Force, comprised of the neighbor island dental coalitions, meet quarterly while the Kauai Dental Health Task Force, the Hawaii Island Dental Task Force, and the Maui Oral Health Task Force continue to meet separately to address the needs of their communities. The groups ensure their efforts mirror the content areas and objectives found in the Task Force's plan. The neighbor island groups continue to be strong advocates for improving children's oral health.

WIC programs educate their clients on baby bottle tooth decay, early childhood caries prevention and the importance of the dental home and regular care.

Title V supports the availability of oral health services through its Primary Care Office activities in two ways: (1) completing the dental health shortage area designation, and loan repayment designations; (2) the provision of state dental health subsidy funds to many of the community health centers. The Community Health Centers which provide oral health services and who receive DOH subsidy are: Kalihi-Palama Clinic; Kokua Kalihi Valley, Waianae Community Health Center, Waimanalo Community Health Center for Oahu County; Bay Clinic and W. Hawaii Community Health Center for Hawaii County; Maui Community Health Center and Molokai Community Health Center for Maui County; and Kauai Community Health Center.

Dental care for children insured by Medicaid-QUEST is part of the Early Periodic Screening Diagnosis and Treatment (EPSDT) Program services for children 0-18 years of age. EPSDT services ensure that children from low-income families receive preventive health care such as well-baby and annual physical exams, immunizations and dental care. The EPSDT services recommend sealants for the first and second molars as preventive dental care. The low-cost health insurance plan for children through Hawaii Medical Services Association (HMSA) also covers sealants for the first and second molars every five years from 0-16 years of age.

Under legislation in 2007, the University of Illinois at Chicago Dental School was contracted by the DOH DHD to perform an assessment of the dental care services in the State. The report was released in 2009 with recommendations to improve the system of services for dental care in the State. Due to the significant economic downturn, there are limitations in the capacity of the public health and public assistance systems to address these recommendations at this time. The Maui Community College's accredited Dental Assistant training program continues to offer low cost dental services to the community at its training site.

Hui No Ke Ola Pono, Maui's Native Hawaiian Health System, employs a dentist that provides preventive education and dental assessments at various elementary schools on the island. The Department of Human Services' Head Start Collaborative shared the "Cavity Free Kids" curriculum from Washington State which has been used by Title V staff statewide.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide oral screenings, education and provide follow-up for serious cases in elementary schools.	X	X	X	X
2. Administer fluoride rinse programs in public schools.	X			
3. Collect, analyze and publish oral health data on children.				X
4. Provide funding for dental services to the under- and uninsured through community health centers.		X		
5. Provide oral health education to WIC low income pregnant women and young mothers.		X		

6. Implement provisions of the Oral Health Action Plan.				X
7. Support Neighbor Island oral health community coalitions to plan and conduct activities/programs.				X
8. Convene key stakeholders to identify and implement specific strategies to improve oral health for children.				X
9. Complete dental health shortage designations through the primary care office.			X	X
10. Administer state funded subsidies to cover oral health services for the uninsured through community health centers.			X	X

b. Current Activities
DHD no longer provides dental services and surveillance of school-age children statewide. The HIOHTF has identified the need for data surveillance as a continuing issue to address.
The dental services on the neighbor islands continue to grow. On Molokai, a Federally Qualified Health Center has been established and has a full time dentist and dental hygienist addressing the critical need for dental care for this rural community.

Three community health centers have expanded dental services with mobile dental vans acquired last year. Bay Clinic has four sites from Hilo to Kau; the West Hawaii Community Health Center services the Kona side of the island and also opened a pediatric dental clinic; and the newest mobile dental van serves the residents in Honokaa and Kohala.

Hawaii was one of 12 states to join the next phase of the national Head Start Dental Home Initiative developed in partnership with the American Academy of Pediatric Dentistry (AAPD). The project goal is to assure all children enrolled in Head Start and Early Head Start (roughly 3,000 low-income children in Hawaii) have dental homes and access to oral health care through a network of pedodontists and trained general dentists. The Hawaii Dental Association is identifying dentists statewide to participate in the program and help train those dentists who usually do not see young children. The Hawaii Head Start launched the project in May 2009 in conjunction with the annual meeting of the AAPD held in Honolulu.

c. Plan for the Coming Year
Title V will explore other options for tracking this measure in the future.

WIC programs will continue to provide oral health education for their clients.

Hawaii is now one of 27 states that have launched a Head Start Dental Home Initiative developed in partnership between the Office of Head Start and the American Academy of Pediatric Dentistry, since 2008. The project goal is to ensure that all children enrolled in Head Start and Early Head Start (approximately 3,200 low-income children in Hawaii) have dental homes and access to comprehensive, continuous oral health care through a network of pediatric dentists and general dentists.

The Hawaii Head Start initiative was launched in May 2009, in conjunction with the annual meeting of the APPD held in Honolulu. Since that time, the following activities have been conducted: informational meetings have been held with dental hygienists and dentists on Hawaii Island, and with dental directors of Community Health Centers; a DVD that focuses on promoting parent awareness about the importance of starting oral health practices early has been produced and will soon be replicated and available for distribution to Head Start/Early Head Start programs to use in parent workshops; plans are being developed to partner Lutheran Pediatric Dental Residents with HS/EHS programs around dental screenings and oral health education activities; and a grant from the Hawaii Dental Services Foundation has been secured to purchase copies of Brush'um and dental starter packs for all HS/EHS enrolled children, statewide. State team meetings are convened quarterly, and Head Start staff attend Neighbor Island Oral Health Task

Force meetings to share information and participate in other oral-health related activities.

Title V also recognizes the serious oral health care challenge for Hawaii's children. Plans are to build on existing infrastructure services by focusing on the utilization of the existing oral health resources, with emphasis on the dental home. Title V staff will continue to collaborate with DHD, the dental providers, pediatricians, and community programs serving families to ensure that each child has an appropriate dental home and is accessing routine care, particularly, children with special needs.

Title V will support the recommendations of the HIOHTF and participate in activities where possible. In addition, FHSD will continue to process the oral health underserved federal designations and continue its state funded grant subsidies to the various community health centers in all four counties.

State Performance Measure 6: *The rate of women aged 15-19 years (per 1,000) with a reported case of chlamydia.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		25	24.1	23.6	23.2
Annual Indicator	26.9	28.8	27.6	34.0	32.7
Numerator	1045	1129	1073	1314	1263
Denominator	38805	39257	38820	38631	38631
Data Source				Hawai‘i State Vital records	Hawai‘i State Vital records
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	22.7	22.2	21.8	21.4	

Notes - 2009
State Performance Measure #06 is the same as Health Status Indicator #05A. Data for the year 2008 was revised with an updated data file. Data for the year 2009 is based on a provisional data file. Data for this measure is from the Department of Health (DOH), Communicable Disease Division, STD/AIDS Prevention Services Branch. Reported positive cases primarily reflect chlamydia infections identified during screening of asymptomatic women. Population data based on U.S. Census Bureau, Population Estimates Program, "Annual Estimates of the Resident Population by Single-Year of Age and Sex for the United States and States: July 1, 2008" (SC-EST2007-AGESEX_RES) (May 1, 2009). Estimates for the 2009 population were not available from the Census bureau at time of this report so the prior year estimate was used in the determination of the indicator.

Notes - 2007
This is a new State Performance Measure added in for the 5-year reporting period, FY 2006-2010. State Performance Measure #06 is the same as Health Status Indicator #05A.

Data is for the calendar year. Data for this measure is from the Department of Health (DOH), Communicable Disease Division, STD/AIDS Prevention Services Branch. Reported positive cases primarily reflect chlamydia infections identified during screening of asymptomatic women. Population data based on U.S. Census Bureau, Population Estimates Program, "Annual

Estimates of the Resident Population by Single-Year of Age and Sex for the United States and States: July 1, 2007" (SC-EST2007-AGESEX_RES) (May 1, 2008).

a. Last Year's Accomplishments

This measure reflects the State priority to reduce adolescent chlamydia. It was selected due to an increase in adolescent chlamydia rates since 1998. The 2009 provisional data indicates a chlamydia case rate of 32.7 for 15-19 year olds per 1,000 females. The objective was not met. Relative to national standards, Hawaii's rate is slightly higher. In 2008 (latest available national data) the U.S. rate for women 15-19 year old was 32.8 per 1,000 compared to 34.0 for Hawaii.

Although the Hawai'i rate went up slightly over the past two years, this may reflect collaborative efforts to increase chlamydia screening. Hawai'i was reported to have the highest screening rate (58.6%) among the 41 states in a Centers for Disease Control (CDC) study that analyzed data from commercial and Medicaid health plans to the Healthcare Effectiveness Data and Information Set (HEDIS) during 2000-07. This data has not yet been updated.

Hawaii did not meet the HP 2010 objective to reduce chlamydia infections among females age 15-24 years attending family planning clinics/sexually transmitted disease (STD) clinics to 3.0%. The Hawaii rate for 2009 was 8.8%. However in FY 2009 the family planning program tested 4,106 clients 25 years and younger a 22.8% increase from 2008 with 3,343 clients these ages tested. This included 2,092 teens ages 19 and younger a 19% increase from 2008 or 1,599 clients tested.

For the Department of Health (DOH), the STD Prevention Program (SPP) is the lead agency for chlamydia. The SPP provides direct services for chlamydia screening and treatment at the only STD public clinic in Honolulu, the Juvenile Detention Center, and in collaboration with community partners, participates in community screening activities. SPP provides STD services on the neighbor islands, utilizing HIV counselors and testers to provide disease intervention activities and STD screening. Statewide partner notification services are available to locate partners of clients with positive test results.

The SPP received an additional $122,000 from the Legislature for 2007-2009. Funds were used to increase STD screening. This additional State funding marked the first funding increase received by the program in 12 years.

Chlamydia screening and treatment services are on 6 major islands through SPP and the DOH Family Planning Program (FPP) agreement. The FPP is part of the Title V agency. The FPP during this timeframe contracted with community health centers, private agencies, doctors, and colleges to provide STD screening and treatment. Numerous FPP and SPP sites are co-located- to ensure services to medically indigent or at-risk populations. The FPP contracts for family planning and STD/HIV education offered to schools, the community, and through health agencies.

Title V oversees service contracts for the Perinatal Support Service program, and the Perinatal Disparities Project that provide STD preventive education and referrals.

The Hawaii TeenLine and website provided STD information for Teen Pregnancy Prevention Month to help educate teens on sexual activity and STD prevention. The SPP and FPP websites provide STD information and list healthcare providers offering free/low-cost STD services for the uninsured.

The Hawaii Youth Services Network (HYSN), a coalition of statewide organizations serving youth, along with Planned Parenthood of Hawaii held a variety of trainings and workshops throughout the state for educators such as "Sex Ed 101", "Contraception 101", and "Science-Based Approaches" with approximately 289 total attendees.

As a result of the 2005 Title V needs assessment, FPP convened an Adolescent Chlamydia Work Group (ACW) with representatives from DOH, Department of Education (DOE), youth providers, American College of Obstetricians and Gynecologists, health insurers and the university. The 2 major goals were: increase condom use among teens and increase screening and treatment. The ACW went on a brief hiatus toward the end of 2009 due to staffing changes. However, the FPP, in collaboration with the SPP, will be re-convening the ACW in Spring 2010 as a task orientated group. Members will include health insurance providers HMSA, AlohaCare and UHAA. Increasing adolescent Chlamydia screening and improving medical management of patient and partners through collaboration and partnerships with employer plans, health care providers and DOH have been an ongoing group focus.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide chlamydia screening, treatment, and prevention education at Department of Health clinic and Juvenile Detention Facility, and through special outreach projects for high risk populations.	X			
2. Provide chlamydia screening, treatment, and prevention education through Family Planning Program contracted clinics; and assessment and referral through the Perinatal Support Services, Perinatal Disparities Project in Hawaii County.	X	X		
3. Provide chlamydia prevention education in schools and in community-based youth service programs.			X	
4. Provide teacher and agency staff training in evidence based curriculums addressing sexual health including STD knowledge and prevention skills.				X
5. Continue Regional Infertility Prevention Project activities to improve reporting and data collection, appropriate screening, timely treatment, use of optimal test technology, and quality assurance to reduce chlamydia.				X
6. Conduct epidemiological analysis of disease activities to determine and evaluate patterns of chlamydia incidence and implement appropriate programs and activities to decrease the positivity rate.				X
7. Improve partner notification and treatment by monitoring the case reports and move toward implementing expedited partner therapy.				X
8. Continue quality assurance and standards development to assure timeliness of treatment and medical management of partners of clients testing positive.				X
9. Identify and implement effective strategies to reduce adolescent Chlamydia through the Adolescent Chlamydia Work Group in partnership with key stakeholders.				X
10. Provide continuing education for healthcare providers and follow-up.				X

b. Current Activities
SPP and FFP screening and education services continue.

The FPP, SPP, and State laboratory representatives participated in the bi-annual CDC Regional Infertility Prevention Project (IPP) to improve screening, timely client and partner treatment, and use of optimal testing. Best practices from other states are shared locally for consideration.

The FPP and SPP supported activities again for this year's STD Awareness Month in April. Activities coincided with Get Yourself Tested (GYT), a national campaign to promote increased youth STD testing. The national website HIVTest.org was updated to include all SPP and FPP sites providing STD testing. GYT promotional resources were used by providers to reach higher risk populations. HMSA supported the Teen Video Award Contest with messages for social health and STD.

As part of the Title V needs assessment, chlamydia was on a short-list of issues submitted by the Women/Infant population workgroup but was not selected as a final State priority. There does continue to be partnership progress in addressing this issue in new ways with insurance companies with an initial ACW meeting in April 2010. There was consensus to collaborate to support a comprehensive approach for messaging, screening and partner management, and improved data collection.

The Title V Women's Health Section coordinated development and distribution of 78,600 women's health screening guides for Women's Health Week, which included chlamydia testing recommenda

c. Plan for the Coming Year

SPP and FFP screening and education services will continue although it is unclear at this time how State budget cuts will impact services. SPP lost a social worker for its STD clinic. FPP TANF funding which covered 50% of community health educator positions was eliminated during FY 2010 (see SPM 01). There are now 35 FPP sites: 4 State funded medical doctor sites and Aloha Medical Mission were discontinued.

Title V Perinatal Support Services (PSS) and Perinatal Disparities Project will continue to provide STD preventive education and referrals. The Baby SAFE Program was eliminated due to 2009 legislative funding restrictions. PSS funds were also cut, reducing the number of pregnant women served.

Region IX IPP activities will continue to decrease chlamydia and gonorrhea positive rates in racial/ethnic minority groups. The FPP health educator and SPP acting program manager will begin Oahu site visits to share service data and improve STD testing.

Expedited Partner Therapy as a tool in partner management of chlamydia has been presented to the State Board of Medical Examiners (BME) in the past, but the Board declined to endorse the practice due to liability concerns and tabled the issue. Fortunately, the BME did not vote to prohibit the practice commonly used by many providers. SPP and ACW partners will approach the BME again when the Board composition appears more open to the practice.

The 2009 Legislature passed a bill requiring all programs receiving State funding to provide medically accurate sexuality education. With the passage of federal health care reform, providers are anticipating more grant opportunities to expand efforts to provide medically accurate/science based sexuality information on STD and teen pregnancy prevention.

The DOE HIV Coordinator will continue to develop strategies to expand sexual health education in the schools. The Hawaii Youth Risk Behavior Survey 2009 data indicates 47.7% of high school students who are sexually active did not use a condom during last sexual intercourse compared to 54.2% in 2007. There was also a decrease in the number of currently sexually active high school students reporting that they or their partner used a condom during last sexual intercourse (47.7% in 2009 compared to 54.2% in 2007) and 80.9% of high school students reported they were taught about AIDS/HIV in school compared to 87.1% in 2007.

The FPP HE participates on the HIV/AIDS Community Planning Group with community

advocates, educators, outreach workers, relatives of individuals living with HIV and those at high risk of infection. This group with the DOH developed a Comprehensive HIV Prevention Plan based on scientific evidence and community needs to guide the State's response to HIV. This plan will be shared with the FPP providers. The FPP is assessing ways to increase chlamydia and HIV prevention service information and testing for HIV high-risk population groups including sexually active youth.

State Performance Measure 7: *Percent of women who report smoking tobacco during pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		8	7.6	7.2	6.8
Annual Indicator	8.4	9.4	8.4	8.5	8.5
Numerator	1440	1716	1548	1592	1592
Denominator	17233	18300	18504	18626	18626
Data Source				Hawai'i State Vital records	Hawai'i State Vital records
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	6.5	6.2	5.9	5.6	

Notes - 2008
Data for the year 2007 is the latest data available.

Notes - 2007
This is a new State Performance Measure added in for the 5-year reporting period, FY 2006-2010.

Data for this measure comes from the Hawai'i Pregnancy Risk Assessment Monitoring System (PRAMS). The Hawai'i State Department of Health started PRAMS in June 1999 as a pilot project. The year 2000 is the first full year of PRAMS data. Data for the year 2006 is the latest data available.

a. Last Year's Accomplishments
Smoking is the single largest known preventable risk factor for poor pregnancy outcomes. The 2008 data (latest available data) indicates 8.5% of pregnant women reported smoking during pregnancy. The State objective of 7.0 % and the Healthy People 2010 objective of 1% were not met.

The 2004-2006 Hawaii PRAMS data shows an average of 21% of women reported smoking just before pregnancy. A substantial percent of women stopped smoking during their pregnancy; however 8.6% of women continued to smoke during pregnancy. Sadly, 64% of women who smoked before becoming pregnant reported smoking in the postpartum period when infants can suffer respiratory ailments and other health problems related to second hand smoke. Maternal characteristics associated with smoking during pregnancy are: under 25 years of age; having Medicaid insurance; unmarried; of Samoan or Hawaiian ethnicity; Hawaii Island resident; lower education levels; and, pregnant multiple times.

Title V continued to administer the Perinatal Health Programs for Department of Health (DOH).

The Perinatal Support Services (PSS) programs provided outreach, screening, health education, case management and care coordination for high-risk pregnant women. PSS providers screened and assessed smoking behaviors using brief intervention (BI) and motivational interviewing (MI) methods.

The Baby Substance Abuse Free Environment (S.A.F.E.) Program, which provided services to substance-using pregnant women, screened for smoking behaviors that would later reveal other substance abuse problems. State funding cuts resulted in the programs' closure in June 2009.

The Healthy Mothers Healthy Babies (HMHB) Coalition provides system building support to improve statewide perinatal services through advocacy and networking. HMHB also manages the State Pregnancy Warmline and website. With funding from the Hawaii Community Foundation, HMHB collaborated with the Kapiolani Medical Center for Women and Children (KMCWC) smoking cessation team to conduct smoking cessation workshops for health providers, neighbor island hospitals and medical centers.

The DOH Basic Tobacco Intervention Skills Certification Program was established to increase screening and smoking cessation counseling skills of health professionals using the 5 A's Tobacco Cessation Counseling Guidelines (Ask, Advise, Assess, Assist, and Arrange), a brief intervention technique.

The WIC Clinic staff continued to screen pregnant women and mothers using the 5 A's guidelines to assess smoking cessation readiness and provide referrals as needed. WIC referred pregnant and parenting women to the DOH statewide Tobacco Quitline and community health centers for smoking cessation classes and interventions.

The federal Healthy Start Big Island Perinatal Disparities program (BIPDP) is implemented through a contract with the Family Support Services of West Hawaii (FSSWH) on the island of Hawaii. The program is designed to decrease the incidence of poor birth outcomes and includes screening for smoking and other risk behaviors.

The Perinatal Addiction Treatment of Hawaii (PATH) Clinic on Oahu provides comprehensive prenatal/postnatal care to substance using pregnant women. PATH provides both clinical and social support services and is administered by the University Department of Obstetrics and Gynecology. The PATH Clinic received funding to provide smoking cessation classes for 3 years that incorporates a holistic approach to cessation using methods such as acupuncture to reduce cravings/withdrawal symptoms, perinatal yoga and Qi Gong for relaxation and meditation. The funding is provided by the Hawaii Tobacco Trust Fund which is financed by the 1998 Master Settlement Agreement (MSA) with tobacco companies.

The Prenatal Smoking Workgroup was established as result of the 2005 Title V needs assessment to convene key public and private smoking prevention and perinatal stakeholders to share information and collaborate on policy and program planning. The group meets quarterly, co-chaired by Title V staff and an Ob-Gyn who is part of the DOH advisory team administering the Tobacco Trust Fund.

Hawaii is one of a handful of states that continues to use a portion of the MSA funds for tobacco prevention. The Hawaii efforts are directed at large scale community norm changes that include policy change, community education, media/countermarketing, resulting in the 5th lowest smoking rate among adults in the U.S.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Conduct the Pregnancy Risk Assessment Monitoring Survey				X

(PRAMS) to collect, analyze and disseminate data on tobacco use before, during and after pregnancy.				
2. Execute and administer contracts for perinatal support services to high-risk pregnant women.	X	X		X
3. Execute and administer contracts for outreach and pretreatment services to pregnant women using tobacco and other drugs.	X	X		
4. Provide outreach and support services during pregnancy and 2 year interconception period through the Hawaii County Perinatal Disparities Grant for risk groups. Services address risk factors for tobacco and other substance use.	X	X		
5. Execute and administer contracts to enhance the statewide perinatal system of care through assessment and advocacy; pregnancy resource referral and information (phone line and website); and, perinatal provider education and training.		X	X	X
6. Provide screening and referral for WIC low income perinatal clients who use substances including tobacco.		X		
7. Support training on smoking cessation interventions for perinatal service providers.		X		X
8. Continue needs assessment efforts through the Prenatal Smoking Workgroup to promote strategies that work in smoking cessation for women before, during and after pregnancy.				X
9. Collaborate on effective strategies to reduce smoking during and after pregnancy as part of the State Tobacco Use and Prevention Plan (e.g. media, counter marketing campaigns, policies for smoking prevention and control use).				X
10. Operate the statewide toll-free smokers Quitline.			X	X

b. Current Activities

Title V staff continues to manage perinatal health programs, participate in smoking cessation activities such as co-chairing the Prenatal Smoking Workgroup, and collaborate with the Tobacco Prevention and Education Program (TPEP), the lead agency for tobacco prevention in DOH.

TPEP developed a bus card and poster, adapted from the American Legacy Foundation, "Great Start" campaign that features a developing fetus smoking a cigarette in the womb. The message targets pregnant women to quit smoking. The posters will be distributed statewide and through PSS providers. A brochure titled, "Stop Smoking For a Healthy Baby," will also be distributed to pregnant women through perinatal healthcare providers.

In March, HMHB sponsored a 2-day workshop at University of Hawaii, with a leading tobacco researcher and tobacco cessation specialist. The workshop provided tools for mental health professionals, including MCH providers, to address smoking cessation for high-risk individuals with co-occurring mental health conditions.

The March 2010 Prenatal Smoking Workgroup meeting considered supporting legislation to have Medicaid reimburse tobacco cessation counseling, but reconsidered given the poor economy. Smoking cessation activities supported by the Tobacco Trust funds shall continue. Despite enormous pressure, tobacco prevention advocates were successful at stopping the diversion of Tobacco Trust Funds to cover the state budget shortfalls during the legislative session.

c. Plan for the Coming Year

Data for PRAMS will be updated in the next year. The objectives for this measure have been set to decrease 5% annually to assure progress in achieving the Healthy People 2010 Objective. The

Title V staff administers PRAMS and will publish a new eight year PRAMS Trend report in 2010.

Title V efforts will continue to screen pregnant women for tobacco use through PSS programs. Pregnant women that are smoking will continue to receive BI and MI in each trimester of pregnancy and the post-partum period as needed. With PRAMS data showing the smoking rate increasing after delivery, strategies to decrease the rate for smoking relapse in the post-partum period will be an area of focus for the Prenatal Smoking Workgroup in addition to the effects of second hand smoke on infants/children.

A planning group has been formed to develop a panel on perinatal issues and the dangers of second hand smoke for the next statewide tobacco prevention conference in September.

The current PSS contracts for high-risk pregnant women ends on June 30, 2011 and a new request for proposal process will be announced for future services. Perinatal health programs to address high-risk health behaviors in pregnancy will need to improve program integration with other community perinatal services to increase coordination and utilize dwindling resources more effectively.

Like many community providers, services like HMHB and the PATH Clinic face the threat of funding cuts in the future due to the poor state economy. HMHB is exploring innovative and more cost-effective social media outreach approaches and plans to implement, TEXT4Baby, a national initiative to promote healthy pregnancy behaviors through mobile phone text messages timed to the pregnant woman's expected due date. The PATH Clinic will continue to provide smoking cessation programs utilizing a holistic approach using Tobacco Settlement funds.

The Big Island Perinatal Disparities (BIPDP) program providers will continue to offer tobacco cessation services to high-risk pregnant women with federal funds allocated exclusively for the Big Island.

The Prenatal Smoking Workgroup will continue to meet and discuss opportunities to increase public awareness on the dangers of smoking in pregnancy, the availability of smoking cessation resources for pregnant women and their families, and related legislation and policies.

WIC will continue to screen clients for tobacco use and provide appropriate referral as required.

DOH Healthy Hawaii Initiative (HHI), chronic disease prevention program, was awarded a CDC ARRA-funded Communities Putting Prevention to Work State Initiative program to expand promotion efforts for the State Tobacco Quitline.

State Performance Measure 8: *Percent of women who report use of alcohol during pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		4.2	4.2	4.1	4.1
Annual Indicator	4.4	6.0	6.0	6.3	6.3
Numerator	755	1088	1107	1167	1167
Denominator	17249	18130	18342	18459	18459
Data Source				Hawai'i State Vital records	Hawai'i State Vital records

Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	4	4	3.9	3.9	

Notes - 2009
Data for this measure comes from the Pregnancy Risk Assessment Monitoring System (PRAMS). Data for the year 2008 is the latest available data, and was carried forward to 2009.

Notes - 2008
Data for the year 2007 is the latest data available.

Notes - 2007
This is a new State Performance Measure added in for the 5-year reporting period, FY 2006-2010.

Data for this measure comes from the Hawai'i Pregnancy Risk Assessment Monitoring System (PRAMS). The Hawai'i State Department of Health started PRAMS in June 1999 as a pilot project. The year 2000 is the first full year of PRAMS data. Data for the year 2006 is the latest data available.

a. Last Year's Accomplishments
This measure reflects the State priority to reduce prenatal alcohol use. The priority was selected based on research demonstrating how alcohol use during pregnancy has many negative effects on the developing fetus. The 2008 indicator is 6.3% (the latest available data). The rate has stayed relatively stable over the past 5 years. The State objective was not met and the Healthy People 2010 objective of 6% was nearly met.

Title V assures provision of statewide support services to high-risk pregnant women through the Perinatal Support Services (PSS) and Baby Substance Abuse Free Environment (Baby S.A.F.E.) service contracts. PSS and Baby S.A.F.E. contract providers use motivational interviewing techniques to screen, counsel, assist and refer pregnant women with substance abuse issues including alcohol use. Unfortunately, the Baby S.A.F.E. Program funding was eliminated and services ended in June 2009 due to the State budget deficit. PSS contracts were extended for an additional 2 year period with less funding allocated to the programs. There was a loss of one contract provider on Oahu and a change of provider on the island of Lanai.

State funding for the Perinatal Addiction Treatment of Hawaii (PATH) Clinic was not renewed but services continue using other funding sources. The PATH Clinic uses the 4P's Plus, a validated screening tool to identify substance use in pregnancy developed by the Children's Research Triangle (CRT), to assess and refer clients for services. Services include comprehensive psychosocial support and prenatal care for women trying to overcome addiction to alcohol, tobacco and other drugs.

In 2007 CRT began working with Hawaii island perinatal stakeholders to develop a universal screening and intervention system for substance use in pregnancy. A plan of action was developed to work with perinatal providers throughout the island to establish a screening, assessment, referral, and treatment (SART) system of care for pregnant women who use alcohol, tobacco, or illicit drugs. All participating providers follow the same protocols, policies, and procedures for screening and follow-up as a component of routine prenatal care including the use of the 4 P's Plus screening tool.

The federal Healthy Start Big Island Perinatal Health Disparities Program (BIPHDP) provides perinatal support services to high-risk pregnant women on Hawaii Island and target women of Hawaiian, Pacific Islander, Hispanic, and Filipino ancestry, and adolescents. Since 2008 the

BIPHDP staff have used the 4P's screening tool to identify client substance use.

The Healthy Mothers Healthy Babies (HMHB) Coalition of Hawaii facilitated training of the 4P's screening tool for PSS providers in April 2009. The Big Island SART project coordinator conducted the training with the goal of establishing a SART system at Oahu community health centers.

The Title V agency maintains a Fetal Alcohol Spectrum Disorder (FASD) position. The Coordinator is responsible for facilitating the development of a comprehensive, statewide system of care for the prevention, identification, surveillance, and treatment of FASD. The Coordinator works with an advisory Task Force which meets quarterly. The Task Force is comprised of members from medical and social service programs as well as parents/guardians of youth affected by prenatal alcohol exposure. The members focus efforts on alcohol warning signage, exploring opportunities to institute early screening for FASD, and a public awareness campaign for FAS International Awareness Day in September. Activities included a Proclamation ceremony with the Lt. Governor and members of the Task Force (which includes the Lt. Governor's wife) and an educational display for public areas/events. FASD prevention informational booklets were created and distributed statewide.

The FASD Coordinator arranged statewide trainings by Dan Dubovsky, federal Substance Abuse and Mental Health Services Administration's (SAMHSA), FASD Specialist. A total of 357 public, private, and community participants attended. The FASD program is also working on assuring FASD screening is done routinely as part of the medical assessment provided when children enter the child welfare services system.

The WIC program screens clients for alcohol use during pregnancy at the initial client visit with a health questionnaire and makes referrals as needed.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Conduct the Pregnancy Risk Assessment Survey to collect, analyze and disseminate data on alcohol use during pregnancy.				X
2. Execute and administer contracts for perinatal support services to assure access to services for high-risk pregnant women statewide.	X	X		X
3. Execute and administer contracts to provide outreach and pretreatment services to substance abusing pregnant women.		X		X
4. Provide Big Island Perinatal Health Disparities Project grant services for target groups through outreach and support services during pregnancy and 2 year interconception period including addressing risk factors for alcohol and other substances.	X	X		
5. Execute and administer contracts to enhance the statewide perinatal system of care through assessment and advocacy; pregnancy resource, referral and information (phone line, website); and, perinatal support provider education and training.				X
6. Build a universal screening, assessment, referral, and treatment (SART) system of care for pregnant women who use alcohol, tobacco, or illicit drugs on Hawaii Island.				X
7. Sponsor training for perinatal service providers on screening and motivational interviewing to effectively identify substance use and encourage clients to change behaviors.		X		X
8. Provide screening and referral for WIC low income perinatal		X		

clients who use substances.				
9. Develop a comprehensive system of care to prevent, identify and treat FASD as directed by the statewide FASD task force and coordinator.				X
10.				

b. Current Activities

The Title V PSS program located at an Oahu community health center began using the 4P's Plus screening tool. The PSS staff are finding that pregnant women are more likely to reveal substance abuse using of the 4P's tool. Perinatal stakeholders continue to discuss the feasibility of using the 4P's as a standard screening tool for all PSS providers.

The FASD Coordinator position was eliminated in December 2009 due to budget cuts, and responsibilities were reassigned to another position on a part-time basis. The part-time FASD Coordinator arranged another series of statewide trainings by Dan Dubovsky, the SAMSHA National FASD Specialist, at nine different sites in February 2010.

The FASD Task Force is continuing to work toward the development of a statewide strategic plan. These efforts focus on promoting use of alcohol warning signage, exploring opportunities to institute early childhood screening for FASD, providing education on FASD to clinical and professional workers, and developing a public awareness campaign for FAS International Awareness Day in September.

In March 2010, Dr. Ira Chasnoff of the CRT presented results of data collected through the Hawaii Island SART project on the first 1,000 clients entering the system through 11 perinatal providers. Alcohol was the major substance used by pregnant women (34.6%) in the project. CRT's efforts were funded through a federal MCH Bureau grant.

c. Plan for the Coming Year

The 2009 PRAMS data will be updated in next year's report. Objectives were set to decrease by 0.1% point every 2 years.

By October 2010 a request for proposals (RFP) will be posted on the State Procurement Office (SPO) website since current PSS contracts expire on June 30, 2011. PSS will continue to focus service provision on high-risk pregnant women. In the absence of the Baby S.A.F.E. programs, the PSS service contract may place more emphasis on providing substance abuse screening, assessment, and referral for treatment. The PSS providers and perinatal stakeholders will continue to discuss the adoption of the 4P's as a standardized screening tool.

Planning for PSS and FASD activities will include collaboration on identifying effective strategies to prevent alcohol use among women of reproductive age and during pregnancy. The FASD Task Force will assist in publicizing and promoting public awareness that drinking alcohol during pregnancy is the leading known cause of mental retardation and birth defects. Promoting awareness among perinatal health professionals will also continue with the possibility of disseminating a toolkit on "Drinking and Reproductive Health: A Fetal Alcohol Spectrum Disorders Prevention" developed by CDC and the American College of Obstetricians and Gynecologists (ACOG). The toolkit contains information on screening, education, and counseling to help clinicians identify, and intervene when they encounter risky drinking in childbearing women, regardless of pregnancy status.

The Healthy Mothers Healthy Babies Coalition of Hawaii service contract with the Title V agency to improve the perinatal system of care will end on June 30, 2011. A RFP to manage the Title V funded pregnancy phone line and a pregnancy resource website will be posted on the SPO website by November 2010. A new contract is expected to be executed by July 1, 2011.

The PRAMS Advisory Steering Committee has begun discussions on revision of the survey questions for the upcoming year. The survey will continue to include questions on alcohol use during pregnancy to monitor Title V and HP 2020 objectives. A proposed objective for HP 2020 is increasing the number of health care providers for women of reproductive age who receive training in the prevention, intervention and treatment of alcohol, tobacco, illicit and recreational drug use.

The BIPHDP, other Big Island perinatal providers and WIC will continue to screen for alcohol use.

State Performance Measure 9: *Degree to which the action plan that supports or facilitates the transition of children & youth with special health care needs to adult life is implemented.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		14	18	21	23
Annual Indicator	7	14	19	21	23
Numerator	7	14	19	21	23
Denominator	28	28	28	28	28
Data Source				Checklist	Checklist
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	24	24	24	25	

Notes - 2009
This State Performance Measure was added for the five-year report period FY2006-2010. This measure is defined and tracked by scores on a checklist of 7 activities that support or facilitate the transition of children and youth with special health care needs to adult life. Scores from 0 to 4 points are based on the degree that these activities are implemented. The checklist item #5 was updated to include youth involvement in other activities including advisory and consultant roles, since these are other ways that youth can provide input into the system of services. A copy of the checklist with scoring criteria is provided as an attachment with the measure narrative in Part IV, Section D.

Notes - 2007
This is a new State Performance Measure added in for the five-year report period FY2006-2010. This measure is defined and tracked by scores on a checklist of 7 activities that support or facilitate the transition of children and youth with special health care needs to adult life. Scores from 0 to 4 points are based on the degree that these activities are implemented. The checklist item #5 was updated to include youth involvement in other activities including advisory and consultant roles, since these are other ways that youth can provide input into the system of services. A copy of the checklist with scoring criteria is provided as an attachment with the measure narrative in Part IV, Section D.

a. Last Year's Accomplishments
This measure reflects the state priority to improve transition to adult life for youth with special health care needs (YSHCN). The 2009 indicator is 23, meeting the objective tracking key activities to improve transition planning services.

The Hilopa'a Project ("Project") was a collaborative effort of the Children with Special Health Needs Branch (CSHNB) and Family Voices, with American Academy of Pediatrics (AAP)-Hawaii and University of Hawaii (UH) Department of Pediatrics to improve integration of systems for CSHCN, including transition services. Hilopa'a, in the Hawaiian language means to "braid firmly"

and is also the name used for the state's Family to Family Health Information Center (F2FHIC). The Project was supported by a MCH Bureau grant.

The Project developed the "Rainbow Book--A Medical Home Guide to Resources for CSHCN and Their Families". The book is a valuable resource for families and professionals to navigate through the complex service system and includes information on transition services to adult life (i.e. higher education and disability access, employment, and vocational rehabilitation). It continues to be used in training for physicians, other health professionals, staff from various state agencies, community programs, families and YSHCN.

The Project also developed a "Transition Planning Workbook" that is used as a guide to facilitate discussions between providers, families, and YSHCN themselves on transition. The workbook identifies tasks/activities, key decisions, timelines and resources important to successful transition planning. Families and YSHCN gain knowledge to enhance decision-making and empowerment needed for transition to adulthood. The workbook has been distributed to other states. Also developed was a four-page "Personal Health Record" form to record critical health information that can be used for transition planning to adult health care.

The Project also supported the implementation of a Pediatric and Family Practice Residency Curriculum which extended teaching knowledge, skills, and attributes of the Medical Home to include integrated service system roles. Sessions included Medical Home conferences with facilitators and parent representatives responding to the pediatric residents' best practice examples; and information on transition. In October 2008, a presentation at the AAP-Hawaii conference addressed transitioning youth to adult health care and included a transition checklist tool for providers.

While the Hilopa'a Project ended in April 2009, the resources developed for transition planning continue to be used throughout the state and are available on the F2FHIC website.

In April 2009, as part of the Title V Needs Assessment, CSHNB conducted a statewide survey of 535 health care providers, advocates, and families to identify the biggest concerns for CSHCN in Hawaii. Of respondents, 25.6% identified transition to adult health care as a problem. In June, transition to adult health care was selected as one of seven new state priority issues.

To clarify the services provided by the Children with Special Health Needs Program (CSHNP), a CSHNP Family Handbook was developed that includes a section on transition planning. The Handbook establishes guidelines, provides standard information, and includes helpful checklists to inform staff practice on the program services including transition planning. The transition planning materials were derived from the Hilopa`a Project documents.
An attachment is included in this section.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Disseminate the Hilopa`a Transition, planning workbook and Personal Health Record for families, providers, and programs/agencies.				X
2. Document, in the Rainbow Book II resource guide, the best practices, protocols, and standards for coordinated care, including transition, between programs and agencies that serve children and youth with special health care needs.				X
3. Provide training on "Navigating the System", which includes transition, to families of children with special health care needs age 0-3 years and to families of middle-school youth prior to age 14 years.				X

4. Provide medical home curriculum that includes transition, to be incorporated into training for pediatric and family physician residents.				X
5. Identify and implement best policies, practices, and standards on transitioning youth with special health care needs to adult health care in selected pediatric and family physician practices.		X		X
6. CSHNP incorporates transition planning into policy and procedures and provides staff training on revised policy/procedures.		X		X
7.				
8.				
9.				
10.				

b. Current Activities
A youth version of the Hilopa'a Transition Planning Workbook, developed by YSHCN, is now available. The CSHNB continues to update the Rainbow Book, including new resources related to transition.

In February 2010, Maui county held its first BIG MAC (Moving Around Community) Transition event targeting special education students (age 14+) and their families. Agencies representing housing, transportation, education, vocational/employment, and health participated in this informational event. The Family Voices coordinator presented on transition to adult life and introduced the Transition Workbook.

In April 2010, CSHNP participated in the Special Parent Information Network conference. The Transition Workbook, Personal Health Record, and other transition information were shared with families and other agency staff.

CSHNP incorporated the FIP and a Transition Checklist into all newly admitted client charts. Staff training related to transition has been conducted and is ongoing.

A Transition Workgroup was formed to work on the state priority issue. Participation includes Neighbor Island representatives. In light the reduction of CSHNP staffing and budget, the Workgroup decided to focus its efforts specifically on transition to adult health care (vs. all aspects of transition). A problem map, resource list, and fact sheet were completed and preliminary activities/ strategies identified to improve services and collaboration with key partners.

c. Plan for the Coming Year
Although the Hilopa'a Project ended in April 2009, CSHNB will continue to work with the Family Voices State Coordinator on updating and producing the Rainbow Book and Transition Planning Workbook, and will support the continuation of trainings conducted by Family Voices/Hilopa'a F2FHIC.

The economic recession and state budget cuts have resulted in major changes to the service system. Many agencies and programs are witnessing an increasing demand for services at a time when public and private funding is being reduced. The Title V needs assessment could not be more timely. The Transition to Adult Healthcare Workgroup will continue assessment activities in this changing service environment, with attention to expanding and updating the list of resources for transition planning and increasing collaboration and partnerships. As collaborative strategies are identified, logic models will be developed to assure activities are feasible, evaluated and result in clear outcomes.

The Workgroup will focus on updating existing transition materials to include the current status of

service programs and coordinate with providers and other community agencies to support families with transition planning to adult health care. Plans are underway for the Workgroup to perform an environmental scan targeting key community programs and agencies. A healthcare provider survey was also drafted for use later to assist with strategy development.

The fact sheet developed by the Workgroup will be used in networking efforts to raise awareness about the importance of transition planning to adult health care for YSHCN, identify the key steps for transition planning, describe some of the issues and barriers faced by YSHCN, available resources, and strategies for collaboration.

The Workgroup is also interested in examining how the passage of federal health care reform will affect CSHN families and impact health care services.

Family needs and social situations are growing increasingly complex and requests for assistance have an urgency not seen before in these numbers. CSHNP will collaborate with key partners to improve utilization of existing services to meet family needs. Greater outreach efforts and communication with community partners can improve coordination and service delivery.

E. Health Status Indicators

Introduction

The series of Health Status Indicators (HSI) provides information and helps portray the health of a population. The indicators can assist maternal child health (MCH) programs by directing public health efforts, guiding surveillance of important MCH indicators, and providing a measure of evaluation. The data is reported on Form 20 and 21.

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	8.2	8.0	7.9	8.1	8.4
Numerator	1464	1521	1515	1567	1585
Denominator	17882	18927	19086	19461	18836
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009

Data is for resident population and is by calendar year. Data for the year 2008 was revised with an updated birth data file. Data for the year 2009 is based on a provisional birth data file.

Notes - 2007

Data is for resident population and is by calendar year. Data for the year 2006 was revised with an updated birth data file. Data for the year 2007 is based on a provisional birth data file.

Narrative:

Low birth weight (LBW) infants are more likely to experience long-term disability or die during the first year of life than normal weight infants. Approximately 2/3 of infants that die within the first year of life are of low birthweight. There are many factors associated with an increased risk of LBW and include race, age, personal history, poverty, maternal smoking, substance abuse, low education, and multiple gestation pregnancies.

About 8.2% of births in Hawaii in 2005 were considered to be of LBW and this rate has changed little since, with 8.4% of births being LBW in 2009. Hawaii remains above the Healthy People 2010 objective of 5.0% of all live births to be LBW. Program efforts to improve perinatal health are found in the narratives for NPM 15-19 and SPM 7 and 8.

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	6.8	6.7	6.6	6.5	6.7
Numerator	1177	1234	1217	1218	1215
Denominator	17376	18368	18563	18820	18223
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Data is for resident population and is by calendar year. Data for the year 2008 was revised with an updated birth data file. Data for the year 2009 is based on a provisional birth data file.

Notes - 2007
Data is for resident population and is by calendar year. Data for the year 2006 was revised with an updated birth data file. Data for the year 2007 is based on a provisional birth data file.

Narrative:
The percentage of infants born in a singleton pregnancy that are LBW has remained fairly stable in Hawaii with 6.3% of births in 2004 and 6.7% in 2009. These rates in Hawaii could be due to many factors including the race/ethnic diversity in Hawaii. Current programs like statewide perinatal support services that target high risk women and women's health promotion programs will continue to impact this number to help decrease the risks of low birth weight in those groups who are particularly at risk for poor birth outcomes. Program efforts to improve perinatal health are found in the narratives for NPM 15-19 and SPM 7 and 8.

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	1.4	1.3	1.2	1.2	1.4
Numerator	242	252	229	235	262
Denominator	17882	18927	19086	19416	18836

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Data is for resident population and is by calendar year. Data for the year 2008 was revised with an updated birth data file. Data for the year 2009 is based on a provisional birth data file.

Notes - 2007
Data is for resident population and is by calendar year. Data for the year 2006 was revised with an updated birth data file. Data for the year 2007 is based on a provisional birth data file.

Narrative:
The percentage of very low birth weight (VLBW) births has been shown to be more directly related to infant morbidity and mortality than low birth weight and is also highly influenced by multiple gestation pregnancies. The overall VLBW percentage in Hawaii in has remained stable with 1.3% in 2004 and 1.4% in 2009. Hawaii exceeds the Healthy People 2010 objective of 0.9%. Current programs like statewide perinatal support services that target high risk women and general women's health promotion programs described in this report must continue to impact this number by promoting interventions that decrease the risks of very low birth weight in those groups who are particularly at risk. Program efforts to improve perinatal health are found in the narratives for NPM 15-19 and SPM 7 and 8.

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	1.0	1.1	0.9	1.0	1.0
Numerator	182	195	170	182	183
Denominator	17376	18368	18563	18820	18223
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Data is for resident population and is by calendar year. Data for the year 2008 was revised with an updated birth data file. Data for the year 2009 is based on a provisional birth data file.

Notes - 2007
Data is for resident population and is by calendar year. Data for the year 2006 was revised with an updated birth data file. Data for the year 2007 is based on a provisional birth data file.

Narrative:

The proportion of VLBW among singleton births in Hawaii was 1.0% in 2009 and this indicator has remained stable over the last 6 years. Current programs like statewide perinatal support services that target high risk women and general women's health promotion programs described in this report continue and strive to impact this number by promoting programs that decrease the risks of very low birth weight in those groups who are particularly at risk. Program efforts to improve perinatal health can be seen in the narratives for NPM 15-19 and SPM 7-8.

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	6.0	5.5	7.6	6.3	5.5
Numerator	14	13	18	15	13
Denominator	234919	237934	237309	236932	236932
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.			Yes	Yes	
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Data is for resident population and is by calendar year. Data for the year 2008 was revised with an updated death data file. Data for the year 2009 is based on a provisional death data file. Population data based on U.S. Census Bureau, Population Estimates Program, "Annual Estimates of the Resident Population by Single-Year of Age and Sex for the United States and States: July 1, 2008" (SC-EST2007-AGESEX_RES) (May 1, 2009). Estimates for the 2009 population were not available from the Census bureau at time of this report so the prior year estimate was used in the determination of the indicator. The reported data maybe too small to calculate reliable measures. Unstable measures are not useful in making decisions. Caution should be exercised in the analysis of the reported data.

Notes - 2008
The reported data maybe too small to calculate reliable measures. Unstable measures are not useful in making decisions. Caution should be exercised in the analysis of the data of the reported data.

Notes - 2007
Data is for resident population and is by calendar year. Data for the year 2006 was revised with an updated death data file. Data for the year 2007 is based on a provisional death data file. Population data based on U.S. Census Bureau, Population Estimates Program, "Annual Estimates of the Resident Population by Single-Year of Age and Sex for the United States and States: July 1, 2007" (SC-EST2007-AGESEX_RES) (May 1, 2008).

The reported data maybe too small to calculate reliable measures. Unstable measures are not useful in making decisions. Caution should be exercised in the analysis of the data of the reported data.

Narrative:
Injuries are the leading cause of death in children after the first year of life. Deaths due to unintentional injuries, specifically motor vehicle accidents is an important measure of children's

health. The death rate in children 14 years and under due to unintentional injury has decreased somewhat to a rate of 5.5 per 100,000 children 14 years and younger, which is encouraging and further reduction in the rate will be important to follow. This indicator has varied from 5.6 in 2004 to a high of 7.6 in 2007, with the rate in 2009 being 5.5.

Infrastructure building efforts have been key to reducing the death rates. Effective analysis and dissemination of child mortality data by the DOH Injury Prevention and Control Program (IPCP) and more recently by the Child Death Review System have helped community advocates to develop policy and program strategies to reduce this rate. Advocacy groups like the Keiki (Child) Injury Prevention Coalition (KIPC) have been vital to assure passage of laws for child safety restraints, conduct public safety education, and promote enforcement efforts. These types of services have likely contributed to the low rate. Other program efforts to reduce child motor vehicle related deaths can be found in the NPM 10 narrative.

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	2.0	2.0	2.7	2.5	2.2
Numerator	14	14	19	18	16
Denominator	710096	706304	715232	712175	712175
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.			Yes	Yes	
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009

Due to the small number of deaths, a three-year annual average is being reported. The reported data maybe too small to calculate reliable measures. Caution should be exercised in the use of the reported data.

Data is for resident population and is by calendar year. Data for the year 2008 was revised with an updated death data file. Data for the year 2009 is based on a provisional death data file. Population data based on U.S. Census Bureau, Population Estimates Program, "Annual Estimates of the Resident Population by Single-Year of Age and Sex for the United States and States: July 1, 2008" (SC-EST2007-AGESEX_RES) (May 1, 2009). Estimates for the 2009 population were not available from the Census bureau at time of this report so the prior year estimate was used in the determination of the indicator.

Notes - 2008

The reported data maybe too small to calculate reliable measures. Unstable measures are not useful in making decisions. Caution should be exercised in the analysis of the data of the reported data.

Notes - 2007

Data is for resident population and is by calendar year. Data for the year 2006 was revised with an updated death data file. Data for the year 2007 is based on a provisional death data file. Calculation based on 3-year moving average. Population data based on U.S. Census Bureau, Population Estimates Program, "Annual Estimates of the Resident Population by Single-Year of Age and Sex for the United States and States: July 1, 2007" (SC-EST2007-AGESEX_RES) (May

1, 2008).

The reported data maybe too small to calculate reliable measures. Unstable measures are not useful in making decisions. Caution should be exercised in the analysis of the data of the reported data.

Narrative:
The death rate in children 14 years and under due to motor vehicle has varied with a rate of 1.9 per 100,000 in 2004 to a high of 2.7 in 2007, with a rate of 2.2 in 2009. The Healthy People 2010 objective (15-15a) for this is to reduce deaths caused by motor vehicle accidents to 9.0 deaths per 100,000 in the general population (4.2 per 100,000 was the national baseline for those 0-14 years of age in 1998). In this age group, Hawaii is doing well and this is likely due to programs described in the narrative for HSI 3A. The continuation of these programs and development of others may help further decrease these unintentional injuries. Other program efforts to reduce child motor vehicle related deaths can be found in the NPM 10 narrative.

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	16.1	16.9	17.3	11.0	19.6
Numerator	28	30	30	19	34
Denominator	174278	177157	173876	173145	173145
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Data is for resident population and is by calendar year. Data for the year 2008 was revised with an updated death data file. Data for the year 2009 is based on a provisional death data file. Population data based on U.S. Census Bureau, Population Estimates Program, "Annual Estimates of the Resident Population by Single-Year of Age and Sex for the United States and States: July 1, 2008" (SC-EST2007-AGESEX_RES) (May 1, 2009). Estimates for the 2009 population were not available from the Census bureau at time of this report so the prior year estimate was used in the determination of the indicator.

The reported data maybe too small to calculate reliable measures. Unstable measures are not useful in making decisions. Caution should be exercised in the analysis of the reported data.

Notes - 2008
The reported data maybe too small to calculate reliable measures. Unstable measures are not useful in making decisions. Caution should be exercised in the analysis of the data of the reported data.

Notes - 2007
Data is for resident population and is by calendar year. Data for the year 2006 was revised with an updated death data file. Data for the year 2007 is based on a provisional death data file. Population data based on U.S. Census Bureau, Population Estimates Program, "Annual

Estimates of the Resident Population by Single-Year of Age and Sex for the United States and States: July 1, 2007" (SC-EST2007-AGESEX_RES) (May 1, 2008).

Narrative:
In adolescents and young adults, aged 15-24 years, the death rate due to motor vehicle crashes has ranged from 11.0 per 100,000 children 15-24 years of age in 2008 to 19.6 in 2009. The Healthy People 2010 objective (15-15a) for this is to reduce deaths caused by motor vehicle accidents to 9.0 deaths per 100,000 people in the population (25.4 per 100,000 was baseline for those 15-24 years of age in 1998). For program efforts to prevent motor vehicle related deaths for adolescents and young adults, see the SPM 4 narrative on underage drinking.

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	262.2	235.8	236.8	210.2	230.4
Numerator	616	561	562	498	546
Denominator	234919	237934	237309	236932	236932
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Data is provided by the Department of Health Injury Prevention and Control Program using data obtained from hospital discharge records acquired from the Hawaii Health Information Corporation (HHIC)-a private, non-profit corporation that maintains a database of health care encounters in the State. Data for 2008 was revised to resident population. Data for the year 2009 data is provisional. Population data based on U.S. Census Bureau, Population Estimates Program, "Annual Estimates of the Resident Population by Single-Year of Age and Sex for the United States and States: July 1, 2008" (SC-EST2007-AGESEX_RES) (May 1, 2009). Estimates for the 2009 population were not available from the Census bureau at time of this report so the prior year estimate was used in the determination of the indicator.

Notes - 2007
Population data based on U.S. Census Bureau, Population Estimates Program, "Annual Estimates of the Resident Population by Single-Year of Age and Sex for the United States and States: July 1, 2007" (SC-EST2007-AGESEX_RES) (May 1, 2008).

Narrative:
Nonfatal injuries is another measure of the health of children as they cause a substantial burden on society due to emergency room visits, hospitalizations, and lifetime medical expenditures due to disabilities. The rate of nonfatal injuries in Hawaii has remained fairly stable ranging from 210.2 per 100,000 children 14 years and under in 2008 to 262.2 in 2005, with the most recent rate in 2009 being 230.4. Programs addressing child injury described in this report (NPM 10) have likely contributed to the rate in Hawaii.

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	46.0	41.6	40.0	27.9	31.7
Numerator	108	99	95	66	75
Denominator	234919	237934	237309	236932	236932
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Data is provided by the Department of Health Injury Prevention and Control Program using data obtained from hospital discharge records acquired from the Hawaii Health Information Corporation (HHIC)-a private, non-profit corporation that maintains a database of health care encounters in the State. Data for 2008 was revised to resident population only. Data for the year 2009 data is provisional. Population data based on U.S. Census Bureau, Population Estimates Program, "Annual Estimates of the Resident Population by Single-Year of Age and Sex for the United States and States: July 1, 2008" (SC-EST2007-AGESEX_RES) (May 1, 2009). Estimates for the 2009 population were not available from the Census bureau at time of this report so the prior year estimate was used in the determination of the indicator.

Notes - 2007
Population data based on U.S. Census Bureau, Population Estimates Program, "Annual Estimates of the Resident Population by Single-Year of Age and Sex for the United States and States: July 1, 2007" (SC-EST2007-AGESEX_RES) (May 1, 2008).

Narrative:
Nonfatal injuries due to motor vehicle accidents is another measure of the health of children as they cause a substantial burden on society due to emergency room visits, hospitalizations, and lifetime medical expenditures due to disabilities. The rate of nonfatal injuries due to motor vehicle crashes in Hawaii has decreased over the past two years with 27.9 per 100,000 children 14 years and under in 2008 and 31.7 in 2009, compared to rates 40.0 and above in years 2004-2007. Programs addressing child injury described in this report (NPM 10) have likely contributed to the rate in Hawaii.

KIPC, IPCP, and the State Department of Transportation have been actively pursuing policies and programs to make Hawai'i's streets safer for pedestrians given the increasing number of highly publicized pedestrian and traffic fatalities over the past few years. The 2005 State Injury Prevention plan targets motor vehicle occupant and pedestrian specific injuries as important priorities to address over the next 5 years.

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009

Annual Indicator	219.8	188.4	161.6	140.9	104.5
Numerator	383	334	281	244	181
Denominator	174278	177257	173876	173145	173145
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Data is provided by the Department of Health Injury Prevention and Control Program using data obtained from hospital discharge records acquired from the Hawaii Health Information Corporation (HHIC)-a private, non-profit corporation that maintains a database of health care encounters in the State. Data for 2008 was revised to resident population only. Data for the year 2009 data is provisional. Population data based on U.S. Census Bureau, Population Estimates Program, "Annual Estimates of the Resident Population by Single-Year of Age and Sex for the United States and States: July 1, 2008" (SC-EST2007-AGESEX_RES) (May 1, 2009). Estimates for the 2009 population were not available from the Census bureau at time of this report so the prior year estimate was used in the determination of the indicator.

Notes - 2007
Data is for resident population and is by calendar year. Population data based on U.S. Census Bureau, Population Estimates Program, "Annual Estimates of the Resident Population by Single-Year of Age and Sex for the United States and States: July 1, 2007" (SC-EST2007-AGESEX_RES) (May 1, 2008).

Narrative:
The number and rate of non-injuries due to motor vehicle crashes among youth aged 15 to 24 has steadily decreased from a high of 219.8 per 100,000 children aged 15 to 24 years in 2004 to a low of 104.5 in 2009. Population based and infrastructure building services described in the narrative for SPM 4 on underage drinking have likely contributed to the significantly low rate in Hawaii. It is important to monitor the recent trends and develop programs to further lower the rate.

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	26.9	28.9	27.6	34.0	32.7
Numerator	1045	1129	1073	1314	1263
Denominator	38805	39020	38820	38631	38631
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009

State Performance Measure #06 is the same as Health Status Indicator #05A. Data for the year 2008 was revised with an updated data file. Data for the year 2009 is based on a provisional data file. Data for this measure is from the Department of Health (DOH), Communicable Disease Division, STD/AIDS Prevention Services Branch. Reported positive cases primarily reflect chlamydia infections identified during screening of asymptomatic women. Population data based on U.S. Census Bureau, Population Estimates Program, "Annual Estimates of the Resident Population by Single-Year of Age and Sex for the United States and States: July 1, 2008" (SC-EST2007-AGESEX_RES) (May 1, 2009). Estimates for the 2009 population were not available from the Census bureau at time of this report so the prior year estimate was used in the determination of the indicator.

Notes - 2007
Health Status Indicator #05A is the same as State Performance Measure #06. Population data based on U.S. Census Bureau, Population Estimates Program, "Annual Estimates of the Resident Population by Single-Year of Age and Sex for the United States and States: July 1, 2007" (SC-EST2007-AGESEX_RES) (May 1, 2008).

Narrative:
Chlamydia can impact reproductive health and is among the most frequently reported communicable disease in the US. High rates are found in sexually active adolescents and young adults, particularly in those 15-19 years of age. In Hawaii, the number and rate of reported cases of Chlamydia among women aged 15 to 19 has remained stable with a rate of 32.7 per 1,000 women aged 15-19 years, in 2009. This indicator has varied from 26.9 in 2005 to 34.0 in 2008.

The related Healthy People 2010 objective (25-1) for this is to reduce the proportion of adolescents and young adults with Chlamydia trachomatis infections with the objectives 25-1a (reduce the proportion of females aged 15-24 attending family planning clinics to 3.0%, baseline 5.0% in 1997) and 25-1b (reduce the proportion of females 15-24 years attending STD clinics to 3.0%, baseline 12.0% in 1997). The higher rates recently may be due to an increased awareness and screening efforts in the population or other factors. Programs designed to reduce Chlamydia for this age group are described in SPM 6.

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	13.5	13.7	14.4	14.2	14.5
Numerator	2905	2909	3027	2993	3040
Denominator	215645	212814	210671	210227	210227
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Data for the year 2008 was revised with an updated data file. Data for the year 2009 is based on a provisional data file. Data for this measure is from the Department of Health (DOH), Communicable Disease Division, STD/AIDS Prevention Services Branch. Reported positive cases primarily reflect chlamydia infections identified during screening of asymptomatic women.

Population data based on U.S. Census Bureau, Population Estimates Program, "Annual Estimates of the Resident Population by Single-Year of Age and Sex for the United States and States: July 1, 2008" (SC-EST2007-AGESEX_RES) (May 1, 2009). Estimates for the 2009 population were not available from the Census bureau at time of this report so the prior year estimate was used in the determination of the indicator.

Notes - 2007
Population data based on U.S. Census Bureau, Population Estimates Program, "Annual Estimates of the Resident Population by Single-Year of Age and Sex for the United States and States: July 1, 2007" (SC-EST2007-AGESEX_RES) (May 1, 2008).

Narrative:
The burden of Chlamydia among adult women in Hawaii has remained stable with a rate of 14.5 per 1,000 women aged 20-44 years, in 2009. Over the past 6 year, this indicator has varied from 13.5 in 2005 to 17.7 in 2004.

The related Healthy People 2010 objective (25-18) for this is to increase the proportion of primary care providers who treat patients with sexually transmitted diseases and who manage cases according to recognized standards. Other related objectives are 25-1a (reduce the proportion of females aged 15-24 attending family planning clinics to 3.0%, baseline 5.0% in 1997) and 25-1b (reduce the proportion of females 15-24 years attending STD clinics to 3.0%, baseline 12.0% in 1997). There has been a greater awareness in the general population and improved screening methods and programs. However, the impact of these efforts are not well characterized. Program efforts to reduce chlamydia can be found in SPM 6.

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	16504	1878	43	566	4752	8396	0	869
Children 1 through 4	67111	6367	219	334	30881	27473	0	1837
Children 5 through 9	74101	8523	32	370	32567	30401	0	2208
Children 10 through 14	71936	8443	825	120	32709	27429	0	2410
Children 15 through 19	83410	10468	738	321	40166	29479	0	2238
Children 20 through 24	69282	5235	465	181	34000	27292	0	2109
Children 0 through 24	382344	40914	2322	1892	175075	150470	0	11671

Notes - 2011

Narrative:
Demographically, Hawaii is diverse and very multi-cultural and this is reflected in its' children between the ages of 0 and 24. A high proportion of children are of Asian (45.8%) and Native

Hawaiian or other Pacific Islander (39.4%), with smaller proportions being White (10.7%), Other/Unknown (3.1%), Black (0.6%), and American Indian/Alaskan Native (0.5%). Of note is that multiple race status was not reported in the survey data.

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	12863	3085	558
Children 1 through 4	55035	13652	828
Children 5 through 9	60895	15286	196
Children 10 through 14	59655	13023	312
Children 15 through 19	69957	13673	142
Children 20 through 24	58356	10471	736
Children 0 through 24	316761	69190	2772

Notes - 2011

Narrative:
Overall 17.9% of children report a Hispanic/Latino ethnicity with just 0.7% not reporting an ethnicity. There was little variation by age in regards to ethnicity.

Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

CATEGORY Total live births	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Women < 15	13	1	1	0	3	7	0	1
Women 15 through 17	419	19	6	6	97	284	0	7
Women 18 through 19	1123	101	21	21	251	713	0	16
Women 20 through 34	14035	3340	344	223	4524	5389	0	215
Women 35 or older	3244	700	47	37	1665	750	0	45
Women of all ages	18834	4161	419	287	6540	7143	0	284

Notes - 2011

Narrative:
The demographics of women in Hawaii with a live birth is diverse. A high proportion of women are Native Hawaiian or other Pacific Islander (37.9%) and Asian (34.7%) with smaller proportions being white (22.1%) or black (2.2%). There was significant variation by age, with 74.5% births

occurring to women between the ages of 20 and 34 years of age and 2.2% of births were in women under 18 years of age and a total of 13 births were to women under the age of 15. There was substantial variation by race and age groups, with Native Hawaiians or Other Pacific Islanders having birth at younger ages with 7 of the 13 births to women under the age of 15, 67.8% of births in women 15 to 17 years of age, and 63.5% of births in women 18 to19 years of age. In comparison, births to mothers who were 35 years and older were most common in Asian women (51.3%), while NHOPI (23.1%) and White (21.6%) women had similar proportions of births.

This measure does not reflect the large percentage of Hawaii residents that identify with more than one race. This data is from Office of Health Status Monitoring based on birth certificate data for which race has been coded to a single race group, and thus does not reflect the multicultural nature in Hawaii. A recent study by the National Centers for Health Statistics showed that a 33.4% of mothers who had a live birth in 2003 and 32.4% of fathers should be considered to be of multiple race based on the five federally designated groups (White, Black, American Indian/Alaskan Native, Asian, and NHOPI).

Programs that target young Native Hawaiian or Other Pacific Islanders women and their partners should be an important focus for public health programs. Programs that ensure adequate screening for increased risk in pregnancy in Asian mothers due to births in later ages is also important.

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

CATEGORY Total live births	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Women < 15	11	1	1
Women 15 through 17	290	127	2
Women 18 through 19	809	310	4
Women 20 through 34	11622	2390	23
Women 35 or older	2925	316	5
Women of all ages	15657	3144	35

Notes - 2011

Narrative:
Overall, a Hispanic/Latino ethnicity for the mother occurred in 16.7% of births in 2009, and was not recorded in <0.2% of women who had a live birth. There was some variation in the proportion of births by age for each ethnicity. Within all Hispanic/Latino maternal ethnicity births in 2009, 4.1% were in those under 18 years of age, 9.9% in those 18 to 19 years of age, 76.1% in those between the ages of 20 and 34, and 10.1% of births in women 35 years and older. This compares to those that did not report being of Hispanic/Latino ethnicity which had 1.9% under 18 years of age, 5.2% were 18 to 19 years of age, 74.2% were 20-34 years of age, and 18.7% were over 35 years of age.

Programs that target young Hispanic women and their partners should be an important focus for public health programs.

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	108	10	7	0	30	57	0	4
Children 1 through 4	13	2	0	0	2	9	0	0
Children 5 through 9	13	3	1	0	2	7	0	0
Children 10 through 14	4	0	0	0	1	3	0	0
Children 15 through 19	46	8	0	0	11	27	0	0
Children 20 through 24	69	19	1	0	12	36	0	1
Children 0 through 24	253	42	9	0	58	139	0	5

Notes - 2011
Data is not collected for category "More than one race reported."

Narrative:
The demographic differences between the resident population and child deaths from 0 to 24 years of age should help identify particular groups at increased risk. There was some variation by age, with the majority of child deaths (47.8%) in children under the age of 5. The greatest number and proportions occurred in infants under 1 year of age (42.7%). Additional variation was found by race where a high percentage of child deaths were in Native Hawaiian or Other Pacific Islander (54.9%), Asian (22.9%), or White (16.6%).

This measure does not reflect the large percentage of Hawaii residents that identify with more than one race. This data is from Office of Health Status Monitoring based on birth certificate data for which race has been coded to a single race group, and thus does not reflect the multicultural nature in Hawaii. A recent study by the National Centers for Health Statistics showed that a 33.4% of mothers who had a live birth in 2003 and 32.4% of fathers should be considered to be of multiple race based on the five federally designated groups (White, Black, American Indian/Alaskan Native, Asian, and NHOPI).

Health Status Indicators 08B: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

CATEGORY Total deaths	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	76	32	0
Children 1 through 4	12	1	0

Children 5 through 9	10	3	0
Children 10 through 14	2	2	0
Children 15 through 19	38	8	0
Children 20 through 24	61	7	1
Children 0 through 24	199	53	1

Notes - 2011

Narrative:
Hispanic or Latino ethnicity was reported in 20.9% of deaths in 2009. There was some variation in ethnicity by age of death with the deaths among Hispanic or Latinos tending to be younger. In the non Hispanic or Latino child deaths, 38.2% were to infants and 49.7% were to children between the ages of 15 and 24. This compares to the Hispanic or Latino child deaths, 60.4% were to infants and 28.3% of the deaths were to children between the ages of 15 and 24.

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**	**Specific Reporting Year**
All children 0 through 19	313062	35679	1857	1711	141075	123178	0	9562	2008
Percent in household headed by single parent	12.4	32.4	13.7	0.0	9.4	9.9	0.0	15.9	2008
Percent in TANF (Grant) families	3.5	7.1	14.2	3.2	1.3	5.0	0.0	0.0	2009
Number enrolled in Medicaid	119622	22717	1593	327	36954	57879	18	134	2009
Number enrolled in SCHIP	24090	4840	227	54	9672	7945	0	1352	2009
Number living in foster home care	2866	351	75	18	292	1486	454	190	2009
Number enrolled in food stamp program	51114	9977	892	168	10026	30022	0	29	2009
Number enrolled in WIC	46765	7634	797	91	7179	8239	22683	142	2009
Rate (per 100,000) of juvenile crime arrests	4753.0	9985.0	8801.0	494.0	2539.0	4337.0	0.0	21529.0	2008

Percentage of high school drop-outs (grade 9 through 12)	4.6	4.9	4.1	6.9	2.8	6.1	0.0	5.9	2009

Notes - 2011
Of the 22,683 reported in the "More than One Race Reported" category, 18,516 is Native Hawaiian or Other Pacific Islander.

Narrative:
Race data may be collected or reported in various methods by different data sources. For example, some programs may only collect or report a single race group, whereas others report out a multiple race group for all those who report more than one race. In this indicator, program specific proportion estimates were used when available.

In 2008, 12.4% of children aged 0-17 lived in a single parent household. There was some variation by race with 32.4% of white children having much higher estimates than Black (13.7%), Native Hawaiian or Other Pacific Islander (NHOPI) (9.9%), and Asian (9.4%) children. Those that were in the other/unknown group was intermediate with 15.9% and consists primarily of those who reported being Mexican or Puerto Rican in the Hawaii Household Survey (HHS) used as a data source for this indicator.

There were 10,875 children in TANF (grant) families in 2009 program data which represented 3.5% of all children based on 2008 HHS estimates. Black (14.2%), and whites (7.1%), and NHOPI (5.0%) having the highest proportions. Only 1.3% of those in the Asian aggregated race group lived in TANF (grant) families. The race specific estimates were based on the 2008 HHS estimate for the individual subgroups, but it is unclear if the white group was collected by both the program and HHS in the same manner.

There were 128,250 children 0-19 years of age enrolled in Medicaid with the largest numbers in the NHOPI (57,879), Asian (36,954), and white (22,717) populations. Proportions were not calculated to describe this indicator due to variability in how race was collected by the program and the HHS.

There were 24,090 children enrolled in SCHIP with the largest numbers in the Asian (9,672), NHOPI (7,945), and white (4,840) race groups. Proportions were not calculated to describe this indicator due to variability in how race was collected by the program and the HHS.

The number of children reported living in foster care in 2009 was 2,866 with the largest number occurring in the NHOPI (1,486) race group.

There were 46,765 children enrolled in WIC programs in 2009 with the highest numbers reported in the multiple race (22,683), NHOPI (8,239), white (7,634), and Asian (7,179) groups.

Data from 2008 demonstrates an overall juvenile crime arrest rate of 4,753 per 100,000 children aged 0-17 years with the highest rate in the "Other and Unknown" (21,529), white (9,985) ,and Black (8,801) race groups. NHOPI (4,337) and Asian (2,539) had somewhat lower rates. The collection of the "Other and Unknown" race is inconsistent between the HHS and Uniformed Crime Reports so the significance of the high rate in the "Other and Unknown" group is not known.

In 2009, an estimated 4.6% of children were high school drop outs with the highest proportion in American Indian or Alaskan Native (6.9%), NHOPI (6.1%), and Other/Unknown (5.9%) children.

These percentages were obtained directly from the program data and do not use the estimates from the HHS.

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**	**Specific Reporting Year**
All children 0 through 19	258405	58719	2036	2008
Percent in household headed by single parent	14.3	4.4	0.0	2008
Percent in TANF (Grant) families	3.8	1.8	0.0	2009
Number enrolled in Medicaid	119622	8628	0	2009
Number enrolled in SCHIP	22738	1352	0	2009
Number living in foster home care	2676	145	45	2009
Number enrolled in food stamp program	47193	3894	27	2009
Number enrolled in WIC	36649	10052	64	2009
Rate (per 100,000) of juvenile crime arrests	0.0	0.0	0.0	2008
Percentage of high school drop-outs (grade 9 through 12)	4.6	5.4	0.0	2009

Notes - 2011

Narrative:
Ethnicity data may be collected or reported in various methods by different data sources. In this indicator, program specific proportion estimates were used when available. Caution must be exercised when comparing to other state estimates, as a large number of persons in Hawaii within some Asian groups report being of Spanish origin.

In 2008, 14.3% of children aged 0-17 who were not Hispanic or Latino that lived in a single parent household compared to just 4.4% of those who reported a Hispanic or Latino ethnicity. The HHS did not report data for children living in households headed by a single parent in those that failed to report an ethnicity.

In 2009, of children who were not Hispanic or Latino aged 0-19, 3.8% were in TANF (grant) families, compared to 1.8% of those who did report a Hispanic or Latino ethnicity based on 2008 HHS Estimates and 2009 Program data.

In 2009 there were 119,622 children 0-19 years of age who were not Hispanic or Latino that were enrolled in Medicaid compared to 8,628 that reported a Hispanic or Latino ethnicity. Proportions were not calculated to describe this indicator due to variability in how ethnicity was collected by the different data sources.

In 2009 there were 22,738 children 0-19 years of age who were not Hispanic or Latino that were enrolled in SCHIP compared to 1,352 that reported a Hispanic or Latino ethnicity. Proportions were not calculated to describe this indicator due to variability in how ethnicity was collected by the different data sources.

The number of children reported living in foster care in 2009 who were not Hispanic or Latino was 2,676, compared to 145 that reported a Hispanic or Latino ethnicity. When using the Hawaii Health Survey 2008 estimates for ethnicity, this translates into 18.3% of those who were not Hispanic or Latino, 6.6% of those who reported a Hispanic or Latino ethnicity, and 1.3% of those that did not report an ethnicity.

In 2009, there were 36,649 who were not Hispanic or Latino that were enrolled in WIC compared to 10,052 that reported a Hispanic or Latino ethnicity. When using the HHS 2008 estimates for ethnicity, this translates into 14.2% of those who were not Hispanic or Latino, 17.1% of those who reported a Hispanic or Latino ethnicity, and 3.1% of those that did not report an ethnicity.

There was no data available in the 2008 report on Crime in Hawaii by ethnicity so no statistics are available.

In 2009, an estimated 4.6% of children who were not Hispanic or Latino were high school drop outs compared to 5.4% who reported a Hispanic or Latino ethnicity. These percentages were obtained directly from the program data and do not use the estimates from the HHS.

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	Total
Living in metropolitan areas	224673
Living in urban areas	224673
Living in rural areas	94486
Living in frontier areas	0
Total - all children 0 through 19	319159

Notes - 2011

Narrative:
Children that live in different environments are exposed to various risks and specific public health programs targeting particular geographic settings may be required. The total number of children between the ages of 0 and 19 years in Hawaii in 2008 was estimated at 319,159. A high proportion of Hawaii's children between the ages of 0 and 19 live in urban (70.4%) compared to rural (29.6%) areas. No children were classified as living in a frontier area. All the children classified as living in an urban area also lived in a metropolitan area. For this indicator, all children living in Honolulu County were considered to be living in an urban or metropolitan area, whereas all children living in Maui, Kauai, and Hawaii Counties were considered to be living in a rural area.

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	1257607.0
Percent Below: 50% of poverty	2.9
100% of poverty	9.3
200% of poverty	27.2

Notes - 2011

Narrative:
Just over 1.2 million people (1,257,607) lived in Hawaii in 2008. Of these, 2.9% live with incomes below 50% of the federal poverty level, 9.3% are in the 50-100% of the federal poverty level, and 27.2% are in the 101- 200% of the federal poverty level. Programs that identify those at poverty may allow better access to health care and various state programs which could influence the health of children.

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	319159.0
Percent Below: 50% of poverty	3.6
100% of poverty	11.6
200% of poverty	34.1

Notes - 2011

Narrative:
Eligibility for several programs (e.g. Medicaid and SCHIP) are partly determined by family income and poverty levels. Participation in these programs can positively influence health. There were 19,159 resident children between 0 and 19 years of age that lived in Hawaii in 2009. Of these, 3.6% live with incomes below 50% of the federal poverty level, 11.6% are in the 50-100% of the federal poverty level, and 34.1% are in the 101- 200% of the federal poverty level. Programs that identify those at poverty may allow better access to health care and various state programs which could influence the health of children.

F. Other Program Activities

THE GENETICS PROGRAM The Genetics Program has been extensively involved in planning, coordinating, implementing, and evaluating statewide activities to improve access to genetic services and education. This includes developing genetics conferences for health care providers and public health staff, newsletters and several websites; maintaining Hawai'i Community Genetics; establishing Neighbor Island genetics services (including telemedicine clinics); working with the Newborn Metabolic Screening Program on current issues such as expansion of disorder panel, quality improvement activities, retention of blood spot, and emergency preparedness; developing the Birth Defects Program; and teaching students, health care providers and the general public about issues in public health genetics. Grant activities have included:
• Western States Genetic Services Collaborative, a multi-state (Alaska, California, Hawaii, Idaho, Oregon, Washington, and Guam) effort to increase the capacity of Alaska, California, Hawaii, Idaho, Oregon, Washington, and Guam genetics and newborn screening programs to perform their assessment, policy development, and assurance functions.
• Sickle Cell Disease Project to develop a standardized follow-up protocol and education about Sickle Cell Disease and Trait for the families with newborns detected via the newborn screening program.
• Newborn Screening Using Tandem Mass Spectrometry: Financial, Ethical, Legal, and Social Issues (FELSI), a multi-state collaboration to research, identify strategies and develop materials

for addressing FELSI.
• Muscular Dystrophy Surveillance, Tracking, and Research Network, a multi-state collaboration to determine the incidence and outcomes of Duchenne and Becker muscular dystrophies.

The Genetics Program continues to work with Guam to develop a comprehensive newborn screening follow-up program.

HAWAII BIRTH DEFECTS PROGRAM (HBDP) is a population-based active surveillance system for birth defects and other adverse pregnancy outcomes. Since 1988, it has been an accurate, complete, and timely source of statewide data on infants with specific birth defects, and pregnancies resulting in adverse reproductive outcomes. It annually finds and collects demographic, diagnostic, and health risk information on 800 to 1,000 infants diagnosed with a birth defect. Data are analyzed for incidence, trends, and clustering, which contribute to the identification of genetic, environmental hazards, and other causes or risk factors. HBDP is funded from $10 of each marriage license fee which goes into a special fund. HBDP was established as a DOH program by the 2002 State Legislature (H.R.S. SS321-421). As part of the transition into the DOH, four HBDP civil service positions were established.

The State Early Childhood Comprehensive Systems grant is funded by the Maternal and Child Health Bureau (MCHB) in recognition of the fact that the early childhood systems building work of the federal, State, and local governments and private foundations over the last 15 years has been impressive, although, the proliferation of early childhood programs from diverse and unconnected service systems left significant gaps between the services that need to be addressed. ECCS is a systems' building grant that supports collaborative partnerships to align early childhood service systems priorities and integrating their funding streams in order to maximize health, mental health, early care and education, parenting education and family support benefits to the children, families, and communities served. Hawaii's ECCS grant continues to partner with state and federal agencies including the Housing and Urban Development (HUD), Departments of Education and Human Services, Aloha United Way, Blueprint for Change, Good Beginnings Alliance, Hawaii Association for the Education of Young Children, Head Start Association of Hawaii, Head Start State Collaboration Office, Kamehameha Schools, Medical Home Works!/Community Pediatrics Institute, University of Hawaii Center on the Family.

SAFE SLEEP HAWAII's goal is to reduce the numbers of deaths through an awareness campaign targeting parents, caregivers, and health care providers. This will be done through: existing programs serving young families, a public awareness campaign, and hospitals with birthing facilities. The committee has begun an outreach campaign using informational packets, PSA's, and educational sessions. Many agencies that service young families are represented on the Committee which functions as a sub-committee of the Keiki Injury Prevention Coalition. This Committee has not met for a time but is being re activated. The MCHB will participate on this committee as it is a natural extension of the efforts of the Child Death Review Initiative and involvement in childhood injury prevention efforts.

DOMESTIC VIOLENCE FATALITY REVIEW The MCH Branch has implemented a Domestic Violence Fatality Review which is a legislative initiative intended to reduce the incidence of preventable deaths related to domestic violence. The DOH is the lead agency to administer statewide team reviews and through this process the MCHB is collaborating with key agencies involved in Domestic Violence. The hope is that thru this collaboration the MCHB can participate in advocacy efforts to improve the systems of care and interventions related to intimate partner violence.

DOMESTIC VIOLENCE SEXUAL ASSAULT SPECIAL FUND AND SEXUAL VIOLENCE/RAPE PREVENTION AND EDUCATION The MCH Branch has a Centers for Disease Control Grant to address Sexual Violence and Rape Prevention Education. This grant provides needed prevention dollars to address this critical issue. The MCH Branch also oversees the Domestic Violence and Sexual Assault Special Fund established by the legislature. This fund and the

programs related to domestic violence/intimate partner violence and sexual violence prevention provides opportunity for the MCHB to expand its efforts toward violence prevention. The Branch is looking at ways to expand the surveillance capacity in these areas and ways to collaborate with other women's health initiatives within the branch, such as family planning and the perinatal programs to assure that women are screened and able to access violence prevention information and services as needed through these service delivery points. The branch continues to find ways to looks at ways to improve coordination and integration between programs.

G. Technical Assistance

Needs Assessment Issue Workgroup members were asked to evaluate trainings provided as part of the Title V needs assessment process and identify other training/technical assistance requests to support further needs assessment work. Because many of the program staff work primarily in the administration and management of specific programs or provide direct/enabling services to consumers, TA is being requested to improve knowledge and skills for systems building.

Also many of the needs assessment priority issue groups are identifying strategies focusing on the development of effective public health messages and understanding effective methods of communicating these messages to target audiences through social marketing and new media.

Other TA requests include support to develop logic models and improve use and interpretation of data. The last two requests will likely be addressed using existing staff resources within FHSD.

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2009		FY 2010		FY 2011	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
1. Federal Allocation *(Line1, Form 2)*	2265527	1451417	2274447		2274139	
2. Unobligated Balance *(Line2, Form 2)*	497888	938955	437770		499384	
3. State Funds *(Line3, Form 2)*	47256973	42257969	25394205		21633241	
4. Local MCH Funds *(Line4, Form 2)*	0	0	0		0	
5. Other Funds *(Line5, Form 2)*	840622	810237	2385281		1697984	
6. Program Income *(Line6, Form 2)*	4018123	3517332	14460407		11427833	
7. Subtotal	54879133	48975910	44952110		37532581	
8. Other Federal Funds *(Line10, Form 2)*	41584290	38433047	43462196		47452298	
9. Total *(Line11, Form 2)*	96463423	87408957	88414306		84984879	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2009		FY 2010		FY 2011	
I. Federal-State MCH Block Grant Partnership	**Budgeted**	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
a. Pregnant Women	3436791	3184986	2757274		2585640	
b. Infants < 1 year old	10414628	7532565	5038892		2902244	
c. Children 1 to 22 years old	10768239	8860444	7431859		4871990	
d. Children with	20157921	19936894	20116336		18386012	

Special Healthcare Needs						
e. Others	8696855	8045435	8232211		7527118	
f. Administration	1404699	1415586	1375538		1259577	
g. SUBTOTAL	54879133	48975910	44952110		37532581	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	1179356		723400		758500	
b. SSDI	94644		94644		93713	
c. CISS	0		0		0	
d. Abstinence Education	162787		122149		0	
e. Healthy Start	925000		1458963		1597605	
f. EMSC	0		0		0	
g. WIC	33814850		33913876		36335708	
h. AIDS	0		0		0	
i. CDC	331340		607931		577258	
j. Education	2138714		3205237		4551250	
k. Other						
other	0		3335996		3538264	
Other	2937599		0		0	

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2009		FY 2010		FY 2011	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
I. Direct Health Care Services	20988333	20175446	20306821		18783804	
II. Enabling Services	20364978	17547582	13668945		10384140	
III. Population-Based Services	3727704	3016527	2827811		1813754	
IV. Infrastructure Building Services	9798118	8236355	8148533		6550883	
V. Federal-State Title V Block Grant Partnership Total	54879133	48975910	44952110		37532581	

A. Expenditures

Significant Budget Variations -- Form 3 (Fiscal Year 2009)

The total Title V Block Grant amount awarded to the State in fiscal year 2009 was $2,265,527. Out of the amount awarded, a sum of only $1,451,417 was expended in federal fiscal year 2009 due to carryovers from fiscal year 2008. The actual expenditures of $938,955 for the category "Unobligated Balance" was higher than the budgeted amount of $497,888 used for the FY 2009 Title V application due to an under estimation of the unobligated balance.

The amount of funds actually expended under the category "State Funds" was $4,999,004 less than the budgeted amount in fiscal year 2009. The decrease in expenditures was largely due to reductions for the Healthy Start Program. The Healthy Start Program received a $3.5 million reduction in State fiscal year 2009. Other major reductions included cuts to operating subsidies for community hospitals ($302,000), and the family planning program ($279,246).

The amount actually expended under the category "Program Income" was $500,791 less than what was budgeted for under this category. The reason for the variance is that the budget ceiling for the Newborn Metabolic Screening Program was established at a higher level than what is currently being expended by the program. In addition, expenditures for the Birth Defects Monitoring Program were below budgeted estimates due to staff vacancies.

Significant Budget Variations -- Form 4 (Fiscal Year 2009)

The amount budgeted for the category "Infants < 1 year old" was $10,414,628, and the actual amount expended was $7,532,565, a difference of $2,882,063. In addition, the amount budgeted for the category "Children 1 to 22 years old" was $10,768,239, and the amount actually expended was $8,860,444, a difference of $1,907,795. The reason for the variances in these categories are primarily due to a $3.5 million reduction for the Healthy Start Program in State fiscal year 2009.

Significant Budget Variations -- Form 5 (Fiscal Year 2009)

The budgeted amount for the category "Enabling Services" was $20,364,978 in fiscal year 2009, and the amount actually expended under this category was $17,547,582, a difference of $2,817,396. This was mainly due to funding reductions for the Healthy Start Program.

The amount budgeted for the category "Population-Based Services" was $3,727,704 in fiscal year 2009, whereas the actual amount expended under this category was $3,016,527, a difference of $711,177. This was due to funding reductions for the Healthy Start Program.

The budgeted amount for the category "Infrastructure Building Services" was $9,798,118 in fiscal year 2009 and the amount actually expended under this category was $8,236,355, a difference of $1,561,763. The variance was due to funding reductions for the Healthy Start Program and vacancies in the Birth Defects Monitoring Program.

B. Budget

The State's maintenance of effort level from 1989 is $11,910,549 and the State's overmatch in fiscal year 2010 is $9,722,692. There is no continuation funding for special projects or special consolidated projects in fiscal year 2011.

Significant Budget Variations -- Form 3 (Fiscal Year 2011)

The "Federal Allocation" category for fiscal year 2011 amounts to $2,274,139. This figure is based on the fiscal year 2010 grant award since the final grant award for fiscal year 2011 has not yet been determined.

The category "Unobligated Balance" is estimated to be $499,384 which slightly more than the fiscal year 2010 amount of $437,770.

As in fiscal year 2010, a significant budget variation in fiscal year 2011 pertains to the category "State Funds." The Family Health Services Division ("FHSD") had reduction-in-force ("RIF") and vacant position abolishments affecting 61.75 permanent full-time equivalency ("FTE") positions in fiscal year 2011. Although 29 State positions were reinstated by the 2010 Hawaii State Legislature, no State funds were provided to fill these positions. Employees were also placed on twice-a-month work furlough for the period October 2009 to June 2011.

Due to the continued stagnation of the State's economy, FHSD received State general fund reductions of 14.81%, or $3,760,964, in fiscal year 2011. This is in addition to State general fund reductions of 44%, or $19,715,324 (adjusted for categorical reclassifications) it received in fiscal

year 2010.

The fiscal year 2011 reductions are primarily due to executive and legislative action as follows:

- $2,773,618 - Reduction-in-force and vacant position abolishments affecting 61.75 permanent full-time equivalency positions
- $685,726 - Reductions for purchase of service contracts. These reductions will impact upon primary care services ($300,000); family planning services ($192,863); and psycho-social (parenting) services ($192,863).
- Twice-a-month work furlough

As indicated in last year's grant application, the most significant budget reduction involved the loss of $11,563,000 in fiscal year 2010 State general funds for the Healthy Start Program. In fiscal year 2011, the Healthy Start Program has dwindled down to one State funded position and approximately $1,320,000 in TANF funding for home visiting contracts with YWCA of Hawaii Island for $670,000, and Child and Family Services (Leeward Oahu) for $650,000. The Healthy Start Program also receives a federal grant of $672,605 to support evidence-based home visitation programs to prevent child maltreatment. Finally, the 2010 Hawaii State Legislature appropriated $1.5 million from the State's emergency and budget reserve fund under Senate Bill 2469 to supplement the Healthy Start Program. This measure, however, has not been signed into law by the Governor as of this writing.

The "Other Funds" category has decreased by $687,297 from fiscal year 2010 to fiscal year 2011. The decrease is primarily due to the elimination of TANF funding for family planning services.

Finally, the category "Program Income" has decreased by $3,032,574 from fiscal year 2010 to fiscal year 2011. The decrease in Program Income is primary due to the elimination of $3 million in Tobacco Settlement funds for the Healthy Start Program in State fiscal year 2011.

Significant Budget Variations -- Form 4 (Fiscal Year 2011)

There is an overall decrease of $7,419,529 for all budget categories from fiscal year 2010 to fiscal year 2011 as it relates to Form 4. As mentioned in the budget narrative related to Form 3, the decrease is due to executive and legislative reductions in State funds, program income, and other funds for fiscal year 2011.

Significant Budget Variations -- Form 5 (Fiscal Year 2011)

As with Form 4, there is an overall decrease of $7,419,529 for all budget categories from fiscal year 2010 to fiscal year 2011 as it relates to Form 5. As mentioned in the budget narrative related to Form 3, the decrease is due to executive and legislative reductions in State funds, program income, and other funds for fiscal year in 2011.

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

For the detail sheets and objectives for the state performance measures developed from the 2010 needs assessment, refer to TVIS Forms, Form 11 and Form 16 under the section “New State Performance Measure Detail Sheets and Data.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.